

HEALTH INSURANCE OPTIONS: REFORM OF PRIVATE HEALTH INSURANCE

HEARINGS BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES ONE HUNDRED SECOND CONGRESS FIRST SESSION

MAY 2 AND 23, 1991

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HEALTH INSURANCE OPTIONS: REFORM OF PRIVATE HEALTH INSURANCE

THURSDAY, MAY 2, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met at 9:30 a.m., in room 1100, Longworth House Office Building, Hon. Marty Russo presiding.

[The press releases announcing the hearings follow:]

(1)

FOR IMMEDIATE RELEASE
FRIDAY, APRIL 19, 1991

PRESS RELEASE #7
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
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THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES HEARINGS ON HEALTH INSURANCE OPTIONS:
REFORM OF PRIVATE HEALTH INSURANCE

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold two days of hearings on health insurance options: reform of private health insurance.

The hearings will be held on Thursday, May 2, 1991, and on Thursday, May 23, 1991, with both beginning at 9:30 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearings Chairman Stark said: "The use of experience rating, medical underwriting, and restricted enrollment are depriving many businesses of the chance to buy comprehensive health coverage at a fair price. I intend to introduce legislation which will assure that every business can buy community-rated insurance without fear of exclusion."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

Various practices of the insurance industry appear to increase the problems faced by employers in purchasing health insurance.

The wide use of experience rating to set premiums, as opposed to community rating, increases prices to small businesses. Other underwriting practices which increase the difficulties of small businesses in purchasing insurance include exclusion of pre-existing conditions, large rate increases for firms with older workers or those in which a worker or dependent has the misfortune to contract a serious illness, the segregation of workers with high risks from group rates, coverage denials, and refusals to renew insurance.

Testimony will be heard on two proposals before the Committee relating to reform of the private health insurance system.

Legislation to be introduced by Chairman Stark prior to the hearing would require all insurance companies to offer community-rated policies on a continuous, open enrollment basis. Under the legislation, medical underwriting would not be allowed, pre-existing condition exclusions would be limited, insurers would be required to offer a minimum benefit plan, and companies which did not meet the standards would be subject to an excise tax.

(MORE)

The legislation would also create a Federal stop-loss pool which would pay the health expenses of high-risk individuals after a deductible was met. The pool would be financed through a reduction in the amount of health insurance expenses which may be deducted.

Legislation introduced by Mrs. Johnson (R., Conn.) and Mr. Chandler (R., Wash.), H.R. 1565, would require the National Association of Insurance Commissioners (N.A.I.C.) to develop model regulations regarding the small group health insurance market (businesses with three to 25 employees.) If the N.A.I.C. did not act, the Secretary of the Department of Health and Human Services would develop the standards. States would be expected to adopt the standards and, if within eighteen months a state did not act, the Secretary would enforce the standards.

Insurers marketing to small employers would be required to offer at least a minimum benefit plan, and they would be required to guarantee that all small employers could purchase the minimum benefit plan. Such plans would be exempt from State benefit mandates. Underwriting criteria would be limited, as well as exclusions for pre-existing conditions. Insurers which were not in compliance with the standards would be subject to a penalty.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Thursday, June 6, 1991, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * CHANGE OF TIME AND LOCATION * * *

FOR IMMEDIATE RELEASE
WEDNESDAY, MAY 15, 1991

PRESS RELEASE #7-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
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WASHINGTON, D.C. 20515
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THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A NEW TIME AND LOCATION FOR THE SECOND HEARING ON
HEALTH INSURANCE OPTIONS:
REFORM OF PRIVATE HEALTH INSURANCE

The Honorable Pete Stark (D., Calif.), Chairman,
Subcommittee on Health, Committee on Ways and Means, U.S. House
of Representatives, announced that the Subcommittee's second
hearing on health insurance options: reform of private health
insurance, originally scheduled for 9:30 a.m., Thursday, May 23,
1991, in the main Committee hearing room, 1100 Longworth House
Office Building, has been rescheduled for 10:00 a.m., in room
B-318 Rayburn House Office Building.

All other details for the hearing remain the same. (See
press release #7, dated April 19, 1991.)

* * * * *

Mr. Russo. The Subcommittee on Health will come to order.

Today the subcommittee continues its series of hearings on health insurance options with a discussion of reform of private health insurance. Reform of private health insurance is an idea which is enjoying increasing support. Many believe the various rating and risk selection practices of the private health insurance industry are increasing the number of uninsured in this country.

Given that almost 34 million of our fellow citizens must do without the basic protection of health coverage, the interest in this issue is not surprising. For these individuals, any encounter with the health care system is likely to have a catastrophic effect.

I believe the time has come to enact a comprehensive reform of the health care financing system and to enact it soon. I have introduced H.R. 1300, the Universal Health Care Act of 1991, which would provide every American with comprehensive, cost-effective health coverage.

I have introduced the Universal Health Care Act because I do not believe that piecemeal approaches will achieve our common goal of universal coverage. I believe strongly that only a universal approach in the public sector can achieve containment of skyrocketing health care costs.

Various practices of the health insurance industry appear to increase the problems faced by companies in purchasing health insurance.

The wide use of experience rating of premiums as opposed to community rating increases prices to many businesses. Other underwriting practices which increase the difficulties of companies in purchasing insurance include exclusions for preexisting conditions and segregation of workers with high risk from group rates.

Insurance companies also may impose large rate increases on firms in which a worker or dependent has the misfortune to contract a serious illness. It seems unreasonable to me that health insurance should become unaffordable simply because someone actually uses the insurance for which they have been paying.

Many experts, including the Pepper Commission, have endorsed the need to stop these kinds of practices. Both the Blue Cross and Blue Shield Association and the Health Insurance Association of America are on record in favor of insurance reform.

Our goal in all of these discussions is to assure that no American lacks basic health insurance coverage. Reform of private health insurance may be a reasonable step to take toward that goal.

To that end, I look forward to hearing from our expert witnesses on the problems of health insurance and about their suggestions on how those problems might be solved.

[Mr. Chandler submitted the following opening statement:]

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EIGHTH DISTRICT, WASHINGTON

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Congress of the United States

House of Representatives

Washington, DC 20515

Statement of
Rep. Rod Chandler
on
Health Insurance Options: Reform of Private Health Insurance
May 2, 1991

I would like to start by commending you, Mr. Chairman, for holding these important hearings.

This subcommittee is all too familiar with the health care crisis that currently confronts this country. It is more than 30 million Americans that have no health insurance of any kind and, health care costs that are now close to 12% of our country's GNP.

With those kinds of figures, I think the members of this subcommittee agree that action of some kind is necessary and, frankly, the sooner, the better. Where we differ, however, is in just what that action should be.

Some of our colleagues would entirely dismantle our existing system in favor of a national, uniform system that would employ a single payor of all health costs (namely, the federal government). While I agree such a system will undoubtedly improve access, I fear it may lead to other, unforeseen problems that will simply leave us with a crisis of a different nature.

I am also concerned that such proposals ignore the fact that despite some obvious problems (i.e. 34 million without health insurance, health costs that are 12% of GNP), the American system of health care delivery does some things very well. My personal feeling is that rather than abandon our current system, we should instead try to improve and build on it; to expand those things we do well and to correct the problems we all know exist.

It is for that reason, Mr. Chairman, that I was pleased to join with our colleague, Rep. Nancy Johnson, in introducing H.R. 1565, the Health Equity and Access Reform Today (HEART) Act.

It is also why I am particularly interested in the testimony of today's witnesses. If we are to retain our current system, then we will have to find ways of improving our private health insurance system; both in terms of cost and access. At the same time, I believe today's health insurers do some things very well. Here again, I believe we should be looking for ways to build on that success.

I also look forward to hearing from Mr. Williams. Having recently had the pleasure of participating in a conference on rural health issues in Spokane, WA, I am very much aware of the problems unique to this country's rural areas; and they are no less urgent or important than those problems that exist in other parts of our society. But again, I think our current system of health care delivery, including private health insurance, can and will play an important role in resolving many of these problems, as well.

Clearly, Mr. Chairman, we have our work cut out for us. And I don't mean to suggest that private health insurance alone is the answer to all of our problems. But I do think the basic concept of a public/private partnership is fundamentally sound and that we, in Congress, should be doing more to build upon it.

To that end, I want to again commend you Mr. Chairman for providing this forum to air some of the concerns regarding our current system of private health insurance. I believe it is crucial to our discussions and that it will prove enormously helpful as we seek to find a lasting solution to our country's health care crisis.

Thank you.

Mr. Russo. Our first witness today is a panel including Donald F. Summers, Anthony Williams, and Charles Hall. If those gentlemen would come forward, Mr. Summers, you will go first, then Mr. Williams, then Mr. Hall. For all of you, your full written statement will be made part of this record. You may proceed to summarize your testimony.

Mr. Summers.

STATEMENT OF DONALD F. SUMMERS, OWNER, AUSTIN WELDER & GENERATOR SERVICE, AUSTIN, TX, ON BEHALF OF THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Mr. SUMMERS. Good morning, Mr. Chairman. My name is Don Summers. I am from Austin, TX. My sons and I own a business in Austin, TX, called Austin Welder & Generator Service. We opened that business in 1978. By 1980, we were able to provide health insurance for ourselves and all of our employees. That insurance was paid for entirely by the company. I have a strong moral conviction that it is the obligation of a small businessman, or any businessman, for that matter, to provide for his employees and their families.

We had to change insurers a number of times. In 1990, we found ourselves in a position where the cost of our health insurance, our monthly payments, exceeded our monthly profits. Our insurance costs had risen 412 percent from January 1987 to May 1990. The portion of that premium payment allocated to buy the contract for my wife and myself increased 512 percent.

As I say, we are a small business. We have nine employees. We repair things like welding machines and power generators. We are a labor-intensive, technical services business. I find it very uncomfortable to not provide this health insurance for my people.

In August of last year, I had to call all my employees together, look them all in the eye, and say as of the 1st of September you will have no health insurance. That is probably the most difficult meeting I have ever had with my employees.

Prior to that decision, we had spent months trying to find a carrier who would pick us up, who would pick up the people who had ongoing problems, who would give us a reasonable rate, who would allow us to be insured. We even went from a \$300 deductible to a \$600 deductible, with no satisfactory reduction in premiums.

I feel that it is essential that someone do something. Mandated insurance is unacceptable to me because when they mandate that I pay the insurance, they don't put any money in my pocket to pay it.

I don't know how I stand on a national health insurance. I am as skeptical of it as are many people in our country. I think the first best step would be to encourage the insurance companies to police themselves. I think community rating is absolutely necessary. I feel that our group of six employees at that time was penalized severely for using the policy, as the chairman just stated.

Mr. Chairman, we need help. I have a 21-year-old man whose wife is going to have a baby. I have a wife who needs, since we canceled our policy, back surgery that is going to cost in the several tens of thousands of dollars. She is, therefore, uninsurable. It is too

late for her, perhaps. It may even be too late for our business. But there are other businesses out there. There are 500,000 small businesses, at least, that need your help. Those are the members of the NFIB.

Thank you, sir, for the opportunity to speak to you, to bring my problems to you. It is a great honor to be here today.

[The prepared statement follows:]

NFIB

National Federation of
Independent Business

ORAL STATEMENT

BY: Donald F. Summers, Austin Welder and Generator Service

BEFORE: House Ways and Means Subcommittee on Health

DATE: Thursday, May 2, 1991

SUBJECT: Health Care Costs and Lack of Access

My name is Don Summers. Thank you very much for the honor and privilege of speaking to you today. I have come to speak to you on behalf of my business, my family and the 500,000 other members of the National Federation of Independent Business regarding the health insurance crisis. The health care crisis influences the continuing operation of all small, family-owned businesses.

Our company, Austin Welder and Generator Service, in Austin, Texas, was started in 1978 by myself and my oldest son. In December of 1978, we were joined by my second son. Our company specializes in the maintenance and repair of electric welding equipment and power generating systems such as emergency back up generators at hospitals and large office buildings.

We currently have nine full-time employees, including family members. We have no part-time employees.

When we started the company in 1978, our gross income was \$16,500. In 1990, our gross income had increased to \$610,000, and our payroll was approximately \$210,000. Our year end net profit was 1.54% or approximately \$9,400.

Since first opening our business, we have felt a very strong moral as well as business obligation to provide quality health insurance for our employees. We began providing that benefit in about 1980, offering health insurance for employees and their families. The cost of this insurance was paid entirely by my company.

Between 1980 and 1990, my business had four different health insurance plans. Under each one, costs became so prohibitive that I was forced to search for a less expensive plan that still provided good coverage.

In 1990 we had to make an extremely difficult decision. In May of that year, the cost of our health insurance had increased to the point that it exceeded our monthly profit after all other expenses had been paid. Despite the increases, our company continued to provide coverage but with a higher deductible. Even by increasing that deductible from \$300 to \$600, we still found the cost of the policy too prohibitive for our company and for our employees.

During that time, our accountant and I spent a great amount of time searching for more affordable coverage. Personally, I have trouble enough keeping up with the advances and changes in our own industry. None of us in our company has the time to become an expert on health insurance. So we must depend on the integrity of an agent or other insurance industry representative to help us make the right choice.

In addition to pursuing higher deductible plans, we looked at other standard plans and HMOs as possible ways to reduce the cost of health insurance to our company. However, our carrier had explained that for companies in our size group, costs were escalating.

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The Guardian of
Small Business

Finally, frustrated and saddened, we had no choice but to cancel our coverage and announce to our employees that as of September 1, 1990, they would have no health insurance. That was, without doubt, the most painful announcement that I have ever had to make. To the best of my knowledge, none of our employees has since acquired health insurance on their own.

In a small business, a good health insurance plan not only reduces the strain and worry on the part of the employee. It also allows us, the employer, to hire better trained, more professional employees. It upsets me not to be able to afford to provide coverage to my employees.

I believe that state health care mandates are a major contributing factor to the increased cost of coverage. In Texas, no basic health plan exists that will allow an employer to purchase a basic health care package. By "basic health care," I mean a policy that might not cover minor illnesses like a cold or sore throat, or other non-life threatening illnesses, but one that would gain access to doctor or hospital care for the more serious illnesses.

A federal mandate requiring small businesses to provide health insurance would, without any doubt, lead to the reduction in size or closure of many businesses. I am convinced that even if the rates for mandated plans were low at the onset, they would soon increase to the point of being too expensive because of medical cost inflation.

The small business is the heart and soul of America. Many of us, as owner/operators of small businesses, are in "face to face" contact with all of our employees every day, and are therefore intimately aware of family health problems. It deeply troubles me to hear of someone needing health care and not getting it because it is too expensive.

Please, gentlemen, help me, other business owners and our employees find basic health insurance packages that are affordable.

Before I close I would like to submit for the record five other statements by small businesses owners from around the country. I was struck by how similar our problems are - we are all caught in a conflict between our values and the prohibitive cost of health insurance.

Thank you very much for today's opportunity to tell you my story.

Mr. Russo. Thank you very much, Mr. Summers, and I know you represent a lot of small businesses in this country that are going through the same problem that you are facing today.

The next witness is Anthony Williams.

Mr. Williams.

STATEMENT OF ANTHONY WILLIAMS, DIRECTOR, RETIREMENT, SAFETY, AND INSURANCE DEPARTMENT, NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION

Mr. WILLIAMS. Good morning, Mr. Chairman. My name is Anthony Williams, and I am the director of the retirement, safety, and insurance department of the National Rural Electric Cooperative Association.

We have a special concern with the enhancement of life in rural America. To this end, we have sponsored several research studies on rural health care, and my statement today is based on the results of those studies.

We have found that rural health care needs mirror those of the Nation, but are further complicated by problems of low incomes, vast distances, other geographic barriers, an inadequate supply of health care resources, and lower coverage rates. We urge Congress to consider rural needs in shaping any health policy options.

Three major conclusions have emerged from our research. The first conclusion is that rural health care needs are deeper than those of urban areas. Rural life is generally believed to be natural and healthy. This image has little to do with reality. Rural residents are sicker than urban residents. They know it and their lives reflect it.

The second conclusion is that rural health care resources remain scarce. The number of physicians practicing in rural areas is increasing, but it remains well below desirable levels. Other health care personnel, particularly nurses, are desperately needed. Further, rural hospitals are facing severe fiscal problems. Change is affecting all hospitals, but we cannot allow our rural communities to be left without any acute or emergency care facilities at all.

The third conclusion is that rural areas face special problems achieving adequate coverage rates. Low rural coverage rates reflect lower income, much lower rates of employer provided coverage, and lower Medicaid enrollment than in urban areas. We have found particular coverage needs in small rural businesses. Nearly 4 out of every 10 employees in these firms are uninsured, or more than twice as many as nationwide. The cost of coverage accounted for at least 40 percent of the uninsured employees in small firms we studied.

We suggest four principles for improving rural health care. The first principle is expanding rural health care coverage. Achieving this goal may require a variety of approaches including private and public action. These approaches will have to be tailored to rural conditions.

The second principle is understanding medical outcomes. The Federal Government has undertaken a major research initiative on medical care outcomes that should consider specific health needs of rural residents.

The third principle is meeting the needs of providers. Even with expanded health care coverage, public support will be needed to maintain some rural physicians and hospitals. Efforts should be undertaken to understand and improve economic conditions of rural medical practices.

The fourth principle is encouraging innovation, promising innovations such as downsize hospitals, which have been tried, and work should continue to be studied, refined, and applied.

Thank you very much.

[The prepared statement follows:]



National Rural Electric Cooperative Association

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TESTIMONY OF THE NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION ON HEALTH INSURANCE OPTIONS: REFORM OF PRIVATE HEALTH INSURANCE

before the

SUBCOMMITTEE ON HEALTH COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES

May 2, 1991

Mr. Chairman and members of the Subcommittee, I am pleased to testify before you today on the state of rural health care. My name is Anthony Williams. I am Director of the Retirement, Safety and Insurance Department of the National Rural Electric Cooperative Association. NRECA is the national service organization of the approximately 1,000 rural electric service systems operating in 46 states. These systems serve more than 25 million farm and rural individuals in 2,600 of the nation's 3,100 counties. Various programs administered by NRECA provide pension and welfare benefits to more than 125,000 rural electric employees, dependents, directors, and consumer-members in these localities.

Our special concern is with the enhancement of life in rural areas. Rural America is home to nearly 23 percent of this nation's population. The most important feature of rural areas is their diversity. Fewer than 1 in 10 rural Americans are farmers. Most work in factories, stores, and business and government offices, just as their urban counterparts do.

We have sponsored several research studies on rural health care. These studies have dealt with health care coverage in small rural firms, the costs of health care coverage for rural residents, and health care needs, resources, and access in rural America. My statement today is based on the results of those studies.

In our research, we have found that, just as the rural economy mirrors that of the nation, so also do rural health care needs. Both urban and rural areas suffer from major health care gaps and needs. More than 1 in 7 Americans lack health care coverage. A similar proportion lacks a regular source of medical care. In short, neither urban nor rural areas are getting enough for their health care dollars.

Rural health care finance and delivery are further complicated by the problems of low incomes, vast distances and other geographic barriers, and inadequate supplies of health care resources. We urge the Congress to ensure that the special needs of rural areas are considered in the design of health care policy. These are the major conclusions that have emerged from our research:

- o Rural health care needs are deeper than in urban areas.
- o Rural health care resources remain scarce.
- o Rural residents are less likely to have health care coverage than their urban counterparts, and pay a larger share of their own health care expenses even at the lowest income levels.

I would like to discuss these findings in some more detail.

Rural Health Care Needs Are Deeper

Rural life is popularly believed to be natural and healthy. This image has little to do with reality, however. Our research found that rural residents are sicker than urban residents, they know it, and their lives reflect it.

Based on federal data, we found that rural residents are about 15 percent more likely than urban residents to experience chronic or serious illnesses. Not surprisingly, their lives reflect their health status. Rural residents are more likely to have medical limitations on their activities. They are also more likely to consider themselves in fair or poor health than their urban counterparts.

Despite resource shortages and poorer health status, rural residents tend to use similar amounts of outpatient and inpatient care as urban residents. Many rural residents must travel far for health care, however, often seeking it in distant urban centers. As a result, we have found that they often delay seeking care until routine problems have become serious.

Rural Health Care Resources Remain Scarce

There is both good news and bad news about rural health care resources. The good news is that number of physicians in rural areas is increasing. The bad news is that physician availability in rural areas is likely to remain well short of desirable levels unless public programs take a more active role in training, recruiting, and retaining rural physicians.

We are concerned about predictions that as many as one in four rural physicians currently in practice could leave their areas within the next five years. These predictions reflect both the adverse economics of rural medical practice and the aging of the rural physician force.

A research study we are currently completing has shown us that rural physicians are special people. They are often the only practitioners for miles around. This means that they are on call nearly all the time. It also means that they must be able to diagnose and treat a wide range of conditions. Healers like this are trained, not born. We applaud the efforts of numerous medical education programs that take special steps to expose their students to this demanding environment and interest them in the many rewards of rural practice. We are not experts in health care, but could medical schools recruit a "senior corp." to relieve these family physicians for vacation and continue education?

Other health care personnel are also needed in rural areas. In particular, the nurse shortage in rural areas is estimated to be about 17 times as large as the physician shortage.

Rural hospitals are facing severe fiscal problems. These problems were exacerbated by adoption of the Medicare Prospective Payment System, but have long predated that system. Most rural hospitals are small and have low occupancy rates. Low patient volumes mean that some will not be able to maintain the standards of health care Americans expect. Fiscal problems for the nation's rural hospitals will intensify as changes in medical practice continue to move increasing amounts of health care outside the hospital setting.

Change is thus affecting all hospitals. But we cannot allow our rural communities to be left without any acute or emergency care facilities at all. Even those communities that may not be able to support an adequate full-service hospital must have access to life-saving care for sudden illnesses or other emergencies. Across the country, several versions of "down-sized" hospitals have emerged to fill this function. Their development must be encouraged if rural health care is not to fall further behind.

Rural Health Care Coverage Rates Are Lower

Some 33 million Americans, or roughly 15 percent of the nonelderly population, lack health care coverage. Rural coverage rates are at least two percentage points lower, reflecting lower rates of both employer-provided coverage and Medicaid enrollment than in urban areas. Our research found particular coverage needs in small rural businesses. Nearly four out of every ten employees in these firms do not have access to employer-sponsored health coverage, compared with fewer than two out of ten employees nationwide, and fewer than 1 out of ten in medium and large firms.

The greatest coverage needs are in the smallest firms. Firms with fewer than 10 employees accounted for 23 percent of the employees we studied but 46 percent of the noncovered workers. Firms with fewer than 10 employees accounted for 72 percent of the firms we studied, but 88 percent of the firms without health coverage.

When smaller employers do offer coverage, their plans often lack some of the safety net features available in larger firms. In particular, retirees and dependents are less likely to be eligible for coverage than nationwide.

Employees in small rural firms are nearly 33 percent more likely to pay for their coverage than employees in larger firms nationwide. One in five covered employees in firms with fewer than five employees pays the entire cost of the plan.

Cost is a major barrier employers face in deciding to offer coverage and is their dominant consideration in choosing and changing plans. Cost barriers accounted for at least 40 percent of the employees without coverage in the firms we studied.

Principles for an Action Agenda

Our research on rural health care suggests a rural health care action agenda based on the following principles:

- o expanding health care coverage;
- o increasing our understanding of medical needs, outcomes, and the effect of various modes of treatment;
- o meeting the needs of providers; and
- o encouraging organizational innovation.

Expanding Health Care Coverage

Rural residents pay the same taxes as urban residents, but get less in both private- and public-sector coverage. Expanding rural health care coverage may require a variety of approaches, including improved risk pooling and other insurance market reforms, expanded tax incentives, direct subsidies, and expansion of public-sector programs. These approaches will have to be tailored to the employment and economic conditions facing rural areas.

Understanding Medical Needs and Outcomes

The federal government has undertaken a major initiative aimed at improving our understanding of medical care outcomes. Such research should also consider the specific needs of rural residents. Why do rural residents remain less healthy despite similar rates of use of medical care? Does rural medical care adequately address rural needs? Conventional medical practice might need to be altered to better meet the needs of the rural poor. Emphasis needs to be placed on prevention as well as "sick" care.

Rural health care research and policy should also address factors outside the health system. Poverty, employment, and housing all affect health status. We need to know how the nonmedical aspects of rural life can be changed to improve rural health.

Meeting the Needs of Providers

Even with expanded health care coverage, public support may be needed to maintain an adequate supply of rural health care providers in many rural areas. Those facilities and medical practices that need and deserve public support must be identified and adequately supported through federal, state and local programs as well as private initiatives. Efforts should also be undertaken to understand and improve the economic conditions of rural medical practices, including revising reimbursement practices in public programs and alleviating the medical liability insurance crisis.

Encouraging Organizational Innovation

Some rural health care improvements can be relatively inexpensive from the point of view of both public- and private-sector budgets. Medical assistance facilities (MAFs), health care cooperatives, nursing centers, and expanded system affiliation are among the organizational innovations that hold promise for improving rural health care delivery. Barriers should be removed that prevent community - based initiatives. These and other innovations should be studied, refined, and applied.

Many urban approaches to health care finance and delivery work in rural areas as well. Others must be adapted to serve rural needs. In turn, many rural approaches -- MAFs are an example -- differ from urban or mainstream models, and require adaptations in regulations and reimbursement arrangements.

Conclusions

Many rural residents are less healthy than urban residents, travel farther for care, and are less able to afford it when they find it. They are less likely than urban residents to benefit from tax incentives and government spending programs aimed at making care more available and more affordable. Poverty, rural economic decline, the demands of an aging population, and geographic constraints complicate health care delivery.

Improving rural health care is not an impossible task, however. Much improvement has already occurred, but more is needed.

Mr. Chairman and members of the Subcommittee, the National Rural Electric Cooperative Association stands ready to assist you in the task you have undertaken.

Thank you.

Mr. Russo. Thank you very much, Mr. Williams.
The final witness of this panel is Charles Hall.
Mr. Hall.

**STATEMENT OF CHARLES P. HALL, JR., PH.D., PROFESSOR AND
CHAIR, TEMPLE UNIVERSITY, PHILADELPHIA, PA, ON BEHALF
OF THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS**

Mr. HALL. Good morning, Mr. Chairman. Thank you.

My name is Charles Hall. I am a professor of health administration and risk management and insurance at Temple University School of Business and Management. I am here this morning to report on the results of an NFIB survey which was randomly drawn from its membership in the spring of 1969 and received over 5,300 responses which we feel are pretty generally representative of small business throughout the United States by region, industry, and so on. The only area of underrepresentation would probably be among the very small—under four employees—and the very young companies that have not yet joined.

The results of the survey clearly show that small businessmen around the country clearly share the concern of most other Americans about the runaway costs of health care and health insurance. They also share the frustration in looking for a solution. Some of the key findings that we think are important for your committee to be aware of are:

Nearly 70 percent of the small businessmen agree that every American is entitled to health care, basic health care, and a nearly similar amount agree that it should be true regardless of the ability of the individual to pay for that care.

Over 90 percent, however, feel that the cost of health insurance is a serious business problem, with a similar percentage indicating that the cost of the coverage has currently become prohibitively expensive. Only 30 percent of the small business owners that we interviewed feel that the cost of health insurance can be passed on to the customers in the form of higher prices, and nearly three out of four feel that adding the cost of coverage to their payroll cost would make it very difficult for them to compete.

Almost 9 out of 10 feel that individuals should have the primary responsibility for their own health insurance, while only about 1 out of 4 agree with Mr. Summers that it is the business owner's responsibility. However, over 50 percent feel that when it is possible, health insurance should be one of the first employee benefits that employers provide, and well over 60 percent would like to provide better or some coverage. Unfortunately, 64 percent or thereabouts felt that they could not afford it at the present time.

Nearly 70 percent disagreed with the idea of requiring insurance, the idea of mandates, and a like percentage feel they simply do not have the resources to do so.

About 63 percent do provide some coverage for their workers at the present time, with just over a third—about 33.8 percent—providing no benefits, and the remainder providing either coverage for all of their workers or at least for some of them.

Not surprisingly, the coverage that was available in this survey was directly related to the size of the firm, to the age of the firm;

in both cases, the larger the number of employees and the older or the longer the firm had been in business, the more likely they were to provide coverage. We found that location played a significant role, with urban companies providing coverage at roughly double the rate of rural firms. There was virtually no variation by region of the country.

Again, it was no surprise to find a direct line relationship between the gross sales or receipts and the owner's salary or draw. The larger those numbers were, the more likely they were to be able to provide coverage.

There was a significant difference, again, by industry type, with agriculture, retail and service businesses being the least likely to provide coverage; whereas, wholesale and manufacturing firms were most likely.

Interestingly, the coverage or the proportion of firms with coverage rose in direct proportion to the number of employees who were heads of households, and it declined as the percentage of part-time employees rose.

We think it is significant that nearly three out of four felt that their employees would prefer at the present time a straight increase in wage rather than an increase in health coverage if they were faced with that choice.

Like most Americans, the small business owners reflected some confusion and frustration in dealing with this problem. Over 60 percent felt the Government should play a more significant role in getting the health care costs under control, but at the same time, less than 13 percent supported a tax increase to take care of the coverage for the poor.

At the same time, it seemed clear that they were not insensitive to the needs of their workers. When those who did provide insurance were asked the reasons for doing so, by far the largest response by nearly 60 percent was that they felt their workers needed it. On the other hand, the ones who were asked why they did not provide it, over 65 percent responded they simply could not pay the premiums.

Since mandates were under discussion at the time of the survey, we did do a small survey on that. And even at very modest levels of mandate, say \$100 per worker per month, which wouldn't buy a great deal in today's market, less than half felt that they could purchase that kind of coverage and remain in business without making serious adjustments. Over 23 percent felt that they would have to discharge all of their employees and perhaps continue as a sole proprietor; whereas, more than one out of five indicated they would drop out of business altogether, which I think would seriously impact on employment.

Finally, lest we think that we are dealing with some very affluent people here, less than 20 percent of the business owners who responded to the survey have personal earnings of \$50,000 or more in a year.

Finally, we asked the question, What would it take to cause you to voluntarily provide health insurance to your workers? The two most common responses were, first of all, increased and/or more stable profits, which, of course, have been somewhat elusive in the current economic conditions; and, finally, a reduction of at least 50

percent in the price of insurance. I think it is safe to suggest that that latter circumstance is not likely to come about.

Thank you very much for the opportunity to present these findings, Mr. Chairman.

[The prepared statement follows:]

NFIB

National Federation of
Independent Business

STATEMENT OF
CHARLES P. HALL, JR., PHD
PROFESSOR AND CHAIR
TEMPLE UNIVERSITY

Before: House Ways and Means Subcommittee on Health
Subject: Health Care Costs and Lack of Access
Date: Thursday, May 2, 1991

I appreciate the invitation to speak at this public hearing on health insurance options.

My purpose here today is to report on the major findings of a health insurance survey conducted by the National Federation of Independent Business Foundation and authored by myself and Dr. John Kuder. The survey consisted of a randomly drawn sample of small business owner members of NFIB in the Spring of 1989. Over 5,300 completed usable surveys were received for a response rate of 29%. We believe that these responses are reasonably representative of small business owners throughout the United States by industry, type and location -- except for those with 4 or fewer employees which are slightly under-represented. In addition, as a group the respondents represent firms that are a bit older and more mature than the universe of small businesses.

The results of the survey support the conclusion that small business owners, like most other Americans, share major concerns about the rapidly escalating costs of health care and health insurance. In addition, the responses reflect the confusion and frustration that result from not being able to identify an easy solution to the problem.

Background

Small businesses have always been a dynamic force in the American economy. They remain so today. Millions of Americans own and operate small businesses. Over 19 million report income or loss from business activity. Self-employment (including small closely held corporations) is the principal occupation for over 9 million Americans and their employees.

Small business has earned a reputation over the past two decades as the nation's "job generator." New firms and those with fewer than 20 employees have been responsible for a disproportionate share of the net new employment generated over the last 20 years. The U.S. Small Business Administration estimated that firms with fewer than 100 employees created 64% of the 10.5 million net new jobs that were created between 1980 and 1986. Small business now employs over half of the private sector workforce.

As will be presented later, the majority of small businesses with fewer than 100 employees do provide health insurance coverage for their employees. Therefore, size alone is an insufficient reason for not sponsoring employee health coverage. This testimony is designed to provide the Committee with insight as to why some small businesses offer health insurance and why others do not.

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The Guardian of
Small Business

Key Findings of the NFIB Foundation Survey

A discussion with any American about his/her health and the health of others is very likely to evoke strong feelings and value statements. Because health care services and health insurance are seen as factors influencing an individual's health and the burden of illness, discussions of these markets are also likely to be affected by strong value judgements. Owners of small businesses are no different. Because they are business owners, they also have strong feelings about the economic viability of their enterprises. In an effort to identify and measure some of these attitudes, the survey incorporated a number of questions about small business owners' attitudes toward general health-related issues and the markets for health care services and health insurance. On many of these issues small business owners disagree among themselves, disagreement that is not easily explained by economic factors. However, on important issues like the right to health care, the cost of health insurance and health services, and the responsibility of businesses to provide health insurance coverage for their employees, there is consensus. Key findings include:

- * 69% of the small business owners agree or strongly agree that every American has a right to basic health care.
- * 63.5% agree or strongly agree that all Americans should receive a minimum level of health care regardless of their ability to pay.

Small business owners across the nation are a diverse group with varied opinions about many issues. They are, however, virtually unanimous in their serious concern about the cost of both health care and health insurance.

- * 92.4% agree that the cost of health insurance is a serious business problem. Note that only 30% of the respondents feel that the cost of employee health insurance can be passed on to customers in the form of higher prices, and 72.7% feel that health insurance costs would raise payroll costs to the point where it would be difficult to compete.
- * 90.3% believe that health care is becoming prohibitively expensive.

These results leave no doubt about how important the cost of health services is to operators of small businesses across the nation. This is consistent with a 1986 study in which small business owners identified "cost of health insurance" as their single most important problem (out of 75 listed problems). Further,

- * 86% feel that individuals themselves have the first responsibility to see that they have health insurance coverage, while only 24.8% believe that employers have a responsibility to provide employee health insurance.

Nevertheless, over half (53.3%) feel that health insurance should be one of the first employee benefits that employers provide, when they are able to do so, and 64.1% said that they would like to provide better (or some) health insurance for their workers. This, perhaps, stems from the fact that 64.3% felt that businesses cannot attract first-rate employees without providing health insurance.

- * Yet, 73.5% of the respondents felt that their employees would prefer a straight wage increase to an increase in health insurance benefits, and 75.9% would be more inclined to handle an increase in compensation through a wage increase.

The economic ability and/or incentive for employers to provide health insurance benefits depends upon the market conditions for their product or service, the labor market conditions from which they obtain their employees, and the firm's particular cost structure. There were significant differences in coverage by industry group, with wholesale and manufacturing firms most likely to provide insurance, while agriculture, retail and service firms were at the other end of the spectrum. Sponsorship of health insurance went up in direct proportion to the percentage of employees that were perceived as heads of households; conversely, coverage declined as the proportion of part-time employees increased.

- * 37.6% of the respondents already provide health insurance benefits for all their employees, while another 25.5% provide benefits for some employees. Just over a third (33.8%) provide no benefits.
- * Not surprisingly, coverage was directly related to the size of the firm (if over 50 employees, 63.4% had coverage for all employees; if less than 5 employees, only 21.2% provided insurance), firm location (nearly 49% of urban firms had coverage, while less than 28% of rural firms did), and the age of the firm (the longer in business, the more likely to have coverage). There was little variation by region of the country.
- * Health insurance coverage also reflected a straight line relationship with both gross sales/receipts and the owners' salary or draw. No surprise here. The access to coverage is determined mainly by the cost of insurance.

It comes as no surprise that over 62% of the small business owners surveyed disagreed or strongly disagreed that "the cost of employee health insurance can be passed on to customers in the form of higher prices." That some disparity exists no doubt reflects the wide range of businesses represented in the survey. Nevertheless, most small business owners clearly did not see a price hike as a variable alternative. Indeed, over four times as many respondents (18.5%) strongly disagreed with the statement that prices could be raised as compared with those that strongly agreed.

We have already seen that small businessmen and women strongly support the idea that all Americans are entitled to some basic level of health care services. They also expressed a majority opinion that the individual should be primarily responsible for his/her own health insurance. However, relatively few believed government should directly pay for health benefits.

Given their limited support for government involvement in paying for health services, it came as no surprise that a substantial number of small business owners felt that "government interferes in health care too much." Respondents were not asked to identify where or how this interference takes place. It is reasonable to infer that Medicare and Medicaid, as the two largest government health care programs, must be major factors.

- * Like most Americans, small business owners reflected some confusion and frustration in dealing with the crisis. Though less than 42% felt that government should pick up the cost of health insurance even for the unemployed, over 60% felt that government must play a more direct role in health care to bring costs under control. At the same time, less than 13% would support a tax increase to support health care assistance to the poor.

More likely, this apparent contradiction reflects the ambivalence that most Americans feel when confronting the complex issues relating to health care. The traditional American reluctance to support "big government" seems to run head-on into a growing frustration with a system that all too many see as being out of control. In grasping for solutions, they may not always think clearly, consistently or logically.

- * Lest it be thought that small business owners are insensitive to the health insurance needs of their workers, it should be noted that when those who had a plan were asked why they instituted them, by far the most common answer was that the employees needed it (59.4%). On the other hand, the most common reason for not having a plan - again by a wide margin - was that premiums are too high (65.3%). This is a classic clash between values and economic reality.

For a number of years, policy makers have openly expressed disappointment regarding the ability of regulatory policy to successfully control the cost of health care. As an alternative, many have supported efforts to rely more heavily on policies designed to increase competition among health insurers and health care providers. Small business owners, most of whom are in very competitive markets, are in a good position to tell us about the degree of competition they witness in the health insurance and health services markets.

- * Nearly 50% of small business owners disagreed with the statement that "insurers compete hard to sell me employee health insurance." Less than 7% felt strongly that there was strenuous competition for their health insurance business. Insurers would probably agree. Few actively compete in the small group health insurance market. However, health insurer competition was not necessarily more strenuous for the business of employers with a larger number of employees and which already offered a health insurance plan than it was for the very small.

The majority of respondents agreed with the statement that there is no real competition among providers of health care services. This small business perception of the health care marketplace is not likely to be shared by health care providers, most of whom feel that they currently face intense competition for market share.

Survey participants were also asked about responsibility for employee health insurance coverage. It is apparent that the majority of respondents felt the primary responsibility for seeing that the employee has health insurance coverage lay with the individual employee and not the employer. Fewer than 6% of respondents disagreed or strongly disagreed with the statement that individuals have first responsibility to see that they have coverage. The majority of small business owners did not believe it was their responsibility to provide employee health insurance, and the smaller the employee group the less likely the owner was to feel this responsibility. In fact, the consequences of mandated benefits would be very negative.

- * 67.1% disagreed with the idea of requiring employers to provide health insurance benefits. Taken in conjunction with the stated desire of over 64% to provide better benefits, this suggests that many small business owners simply do not feel they have the capacity to do so. Even at rather modest levels of costs (e.g., \$50, \$100, or \$150 per employee per month), it was clear that such mandates could have a severe impact. At the

middle range (\$100), less than half (46.3%) felt that they could purchase the mandated insurance and make adjustments elsewhere, while staying in business. Over 23% indicated that they would let all of their employees go and try to continue operating. Another 21.5% simply responded that they would get out of business. Even allowing for some overstatement of their probable reactions, these results suggest that there could be a significant impact on employment from such a mandate.

* Less than 20% of the small business owners who responded to the survey reported personal earnings of \$50,000 per year or more. This suggests that many of them could earn more working for someone else than by maintaining their own business and supporting their families through that business. While most of them are probably willing to pay some price for independence, we cannot ignore the fact that the added burden of mandated insurance coverage could well drive many of them out of business.

* Finally, when those who currently do not provide coverage were asked what would prompt them to voluntarily provide health insurance to their full time employees, the two most frequently mentioned reasons, by a wide margin, were increased and/or more stable profits, and a reduction of 50% in insurance costs. It is safe to say that the latter is not going to happen. There is also emerging an equally serious problem -- the problem of rising health care and insurance costs pricing small business out of the marketplace. The 90% who deemed health insurance as becoming "prohibitively expensive" represent a completely different and difficult problem.

Conclusion

Not unlike other Americans, owners of small businesses seem to be faced with a serious dilemma regarding their values about the provision of health services, the high cost of these services, and who has the responsibility for paying the bill for health care. The vast majority of small business owners feel every American has the right to basic health care and most agree with the statement that Americans should receive a minimum level of health care regardless of their ability to pay. They do not, however, support mandated benefits.

Respondents view the cost of health care and health insurance as a very important and vexing problem. Many business owners believe that because of the high cost of health insurance premiums, their firm's marginal profitability position, and their belief that they could not pass on the cost to customers, providing any (or better) health insurance benefits to their employees would not be a wise financial decision. Further, approximately one-fifth of owners who do not sponsor a plan believe they do not qualify for group health insurance policies, and many owners believe their employees would prefer wage increases to increased insurance benefits.

Furthermore, many are of the opinion that because their employees' families are often covered by the policies of other family members, much of the premium expense would be wasted. Despite the many reasons to not sponsor health insurance, the majority do offer a plan to at least some employees, and another majority indicated they would like to provide better or some health insurance for employees. It all boils down to an issue of cost.

Clearly, the problem of the uninsured is a serious one. There is evidence that most small business owners share concern about the problem with the rest of society, and like the larger body politic, they are unsure of the solution.

Thank you for the opportunity to present these findings.

Mr. Russo. Thank you very much.

Mr. Hall, in your survey and as a result of your conversations with people that you interviewed, how much of the problem do you think is caused by the practices of the health insurance industry, and how much relates to the high and rising costs of health insurance?

Mr. HALL. I believe it is very difficult to separate those two factors, Mr. Chairman. Clearly most of the employers that we interviewed would be interested in providing some coverage if the costs were lower. One of the issues that comes up, of course, is the unavailability of coverage for small firms. In some cases, that seemed to be more perceived than real. But it was clear that they felt, in general, that they were not being actively pursued. Again, a direct relationship between the size of the firm. The smaller firms did not have insurance salesmen trying to sell them policies. The larger firms sometimes did encounter that.

Mr. Russo. Do they feel comfortable about the insurance industry? Did they feel that they were being adequately served by the insurance industry?

Mr. HALL. We didn't have any question that was posed in just that form. I think there was concern in many cases, particularly for the small firms, about the practice of denying coverage for pre-existing conditions, the withdrawal of coverage after policies were in force if a significant claim came through; and many of them felt that the community rating, at least for the universe of small companies, was absolutely essential for them to get the prices under control.

Mr. Russo. Mr. Summers, you are a real live example of what happens in the real world versus all the academics that come here and tell us about economic models.

Mr. SUMMERS. Yes, sir.

Mr. Russo. What is your experience with the insurance industry in trying to deal with the problem as you faced it, as a businessman who wants to provide health insurance for his employees but cannot do so because you are too small? I mean, did you raise this with your agent or with your insurance company, the many years of service, the many years that you paid premiums to these companies, and now all of a sudden they are pricing you right out of the business?

Mr. SUMMERS. I found them to be very insensitive to discussions of that. We were and continue to be inundated weekly by calls from vendors of health insurance contracts, never one offering any better price or any lower priced available product. Our carrier when we canceled was unable or unwilling—I can't say which—to work with us to help us reduce our costs. The only communication we had with them after canceling was a bill for that month's premium because we had not written them that we were canceling.

Mr. Russo. How many years were you with this company before?

Mr. SUMMERS. I beg your pardon?

Mr. Russo. How many years were you with this specific company?

Mr. SUMMERS. Probably 3.

Mr. Russo. Prior to that, how many years were you with the other company?

Mr. SUMMERS. The previous company had been taken over by the final company. So we were with that company maybe 18 months. Because of the size of our group, we didn't get a lot of concern.

Mr. RUSSO. Mr. Williams, anything you care to add to some of these comments that we have heard so far?

Mr. WILLIAMS. Not really. Our special concern is small businesses in rural America. I think the results of our survey generally mirror what this gentleman said, except I don't think we found any great lack of the availability of insurance. Price was the major concern in whether or not a small rural employer provided coverage for his employees.

Mr. RUSSO. Mr. Chandler.

Mr. CHANDLER. Thank you, Mr. Chairman.

Dr. Hall, I thought a very significant point that you made—and I think it deserves to be underscored—is the fact that the owners of those businesses that you surveyed are taking out of their business, as I understand it, a gross salary for themselves of less than \$50,000 a year. Only 20 percent have incomes greater than that.

Mr. HALL. That is correct, sir.

Mr. RUSSO. So we are not talking about upper middle-income America here.

Mr. SUMMERS, is that essentially the situation you find yourself in?

Mr. SUMMERS. Absolutely. I took out less than 40 last year.

Mr. CHANDLER. So health insurance even for yourself is—

Mr. SUMMERS. Unapproachable, as far as a cost basis is concerned.

Mr. CHANDLER. Did you respond to Dr. Hall's survey yourself?

Mr. SUMMERS. I think I did.

Mr. HALL. I believe so.

Mr. CHANDLER. When the question was asked, "Do you think every American has a right to health care?" would you have said yes?

Mr. SUMMERS. Yes.

Mr. CHANDLER. I think that was what about 90 percent responded. Do you feel that the Congress is going to do something at the national level about this?

Mr. SUMMERS. I wish I could read the minds of the Congress. I don't know.

Mr. CHANDLER. The chairman whispered in my ear, "Would you like us to?" I was a small business owner. I didn't even employ nine before I came to Congress. So I understand exactly what you are talking about. We never got more than about \$40,000 a year for our family. There were months where we didn't get anything.

Mr. SUMMERS. That is right.

Mr. CHANDLER. You know all about that, I can see.

Mr. SUMMERS. Yes, sir.

Mr. CHANDLER. I don't know how we keep smiling through all that. The point is that I think what you are suggesting is a piece of legislation that would reduce the cost enough so that you could afford health insurance for yourself and for your employees.

Mr. SUMMERS. Yes, sir.

Mr. CHANDLER. If the Congress could enact a package of legislation which would bring down that cost, and through various mech-

anisms spread the risk, would you as a business owner accept a requirement to offer—not provide or pay for—health insurance for your employees?

Mr. SUMMERS. I don't really see any problem with that. The offer would definitely be made. One thing that I would ask the Congress to keep in mind is the paperwork. With nine people and the time involved, the only thing our business has to sell is labor. And we have an 8-hour block of labor every day from each productive man to sell. If I have to reduce that labor time or if I have to, because of additional paperwork, add another person who is nonproductive—

Mr. CHANDLER. Right. My guess is you weld right along with the people you employ, correct?

Mr. SUMMERS. No, we don't weld. We repair the welding machines.

Mr. CHANDLER. Oh, I see.

Mr. SUMMERS. We are a service. Yes, sir, I do—

Mr. CHANDLER. You do the same thing your employees do, right?

Mr. SUMMERS. Yes, sir.

Mr. CHANDLER. So when you are doing books or something, that is taking away from—

Mr. SUMMERS. Yes, sir.

Mr. CHANDLER. That is the point that you are making. I think that that is something the committee needs to keep in mind.

Then if you had an ability, say, to go to the Austin Chamber of Commerce or NFIB to get an affordable health insurance plan and you paid half, do you think your employees would take advantage of that, if the choice is there?

Mr. SUMMERS. I would do my best to make it possible for them to take advantage of it. If it meant a partial increase in salary so they could pay their portion, I would help them with that because I feel it is an absolute essential that they are protected.

Mr. CHANDLER. One idea that has been floated is that people be required as individuals to carry insurance. Would you favor that idea?

Mr. SUMMERS. That is a tough one.

Mr. CHANDLER. Dr. Hall, did you survey that in your survey of business owners?

Mr. HALL. That particular thing was not surveyed, but I am aware of the proposal you have referred to. I think it was just published a couple weeks ago in Health Affairs.

Mr. CHANDLER. Have you had a reaction or do you have any sense of where NFIB members are on that?

Mr. HALL. I can't speak for NFIB on that, no. I think it is clear from the proposal, however, that it would take some very significant changes in current policy to make that possible, including tax law changes.

Mr. CHANDLER. I would just like to conclude by saying, Mr. Williams, that I attended a conference on rural health care in Spokane, WA not long ago, and everything you said today, the same points were made at that conference as well. I thank you for your testimony.

Mr. RUSSO. Mr. McGrath.

Mr. McGRATH. Thank you, Mr. Chairman.

I thank the gentlemen for your testimony. I am sorry I am a little late.

Dr. Hall, your results indicate that about one-third of the survey respondents provide no employee health insurance. Did your survey ask whether or not these businesses ever provided employee health insurance?

Mr. HALL. No, sir. That was not part of the question.

Mr. McGRATH. It would be interesting to know how many may have dropped their health insurance as a result of increased prices. I am interested in your testimony and your survey, Dr. Hall, because it seems to me that you are testifying in favor of something that the chairman of our subcommittee now is angling for, and that is a single payer, nationalized health insurance system. It seems to me that all of the concerns, including the 98 percent of the people favoring some sort of health plan as a right, would fit right into that. I am wondering whether or not other positions taken by the NFIB, including being against mandated benefits, fits the results of your survey. Could you comment on that?

Mr. HALL. As I indicated, I believe that the results of the survey indicate the kind of confusion and frustration that small businessmen face, the same as the rest of society and legislators in trying to come up with a solution. Actually, the numbers specifically were almost mirror images. It was actually 69 percent that indicated that everyone should have—they either strongly agreed or agreed that every American has a right to basic health care; 67-plus percent said that they did not like the idea of a mandate. By the same token, lots of them say that Government should help, but only 13 percent were willing to pay an added tax so that you could help.

This frustration, I think, is what really came out in the survey.

Mr. McGRATH. I agree. I have friends who are the most conservative types who feel that Government should stay out of everything except in the area of health care, which is something that is separate and special. This is going to be an interesting time in our history. My view is that the frustration that you seem to find in your survey results from several things. Private industry is not happy with the cost of health care. The beneficiaries are not happy with the kind of health care that they are getting, the paperwork and everything else. The doctors are not happy because of the paperwork also and maybe some of their reimbursement rates. It seems to me that the time may be near that something, with all these convergent views going in the same direction, may happen, in spite of what the Washington Post said the other day.

I want to thank you for your testimony. It is very enlightening.

Mr. RUSSO. The gentle lady from Connecticut.

Mrs. JOHNSON. Thank you, Mr. Chairman.

It is interesting that all of your testimony points to the fact that price, not availability, is the problem. That leads to the issue of who should pay the price—since you can't pay the price, should we pay the price? I think the more serious issue is what do we do about the price.

Recently, I read about a company that was providing for a dollar a day hospital insurance for 10 days, which covers 85 percent of the hospital insurance needs of people in America. Now, I may not be quoting that exactly. But what I am getting at is: Here is a creative

little plan out there. It meets one of the very real needs. Coupled with some kind of stop loss insurance at a much higher level, it is promising on the hospital end.

Core benefits, one of you made the point in your testimony—I have forgotten which one now since I skimmed them all—that you don't really need help with little things. You need to know that you would be safe from the physician and hospital costs in a serious illness. Why are there no plans out there that do that? We are supposed to be an inventive market.

What is wrong with our system that nobody is out there providing what you need at a cost you can afford? Mr. Summers?

Mr. SUMMERS. One of the things that has added to the problem, that specific problem, are State mandates. Our insurance contracts written for groups in Texas now must include coverage for such things as in vitro fertilization and numerous other health-related items that I can't remember. There is a good list of them. That does add to the burden of the price.

Mrs. JOHNSON. It certainly is true that invention in the technological area, the medications area, and the medical procedures area have made an awful lot of things possible that weren't possible. As those possibilities are reflected in mandates, the prices go up. If price is the problem and you simply transfer price responsibility to Government without any redelineation of product, then you will simply pay higher taxes to us. I think you have got to be real about this. While there are some administrative costs we could save by changing the way we operate the system—and we could do that under a national program or we could do that under a national policy—I am interested that you point immediately to mandates. I think there is some truth in that.

What about plans that offer some greater variety of options for you? What is the range of prices in Texas?

Mr. SUMMERS. There isn't any range for a small group. There isn't any range.

Mrs. JOHNSON. How many insurers were there in the small group when you went looking?

Mr. SUMMERS. We interviewed at least 15 or 20.

Mrs. JOHNSON. So back to your original point, availability is not the problem. Price is—

Mr. SUMMERS. Availability is a problem. When you are dealing with a small group of people, an insurer doesn't like to pick you up from another company. All the insurers we talked to would pick us up, but they wouldn't pick up those who had ongoing problems.

Mrs. JOHNSON. Well, I think that is exactly the kind of thing that our reforms will address. But you have to couple the addressing of those problems in the market that exclude people who need health care with a basic plan. Otherwise, all you get is what you got.

Mr. SUMMERS. That is right.

Mrs. JOHNSON. Except a shift in how you pay the bill. You are going to pay the bill through Federal taxes rather than through premiums. If you look at our track record in defense procurement, you may pay a higher cost for us procuring health care than for you to procure it through the private sector.

Mr. SUMMERS. I agree with you.

Mrs. JOHNSON. I am interested that mandates is clearly a problem that you have seen functionally out there denying you options. I am very interested that your survey, Mr. Hall, shows not only such deep concern with health care as a right, but also with individual responsibility, that individuals have some responsibility toward their own provision of health care. In many ways, this is the only way to keep them in the loop about whether or not they care if they smoke or are overweight, and so forth.

So I think if we are going to look at price, we have got to look at product and consumer habits as well. If you simply transfer the responsibility to Government, you lose the ability to manage both of those aspects. So I appreciate your insight. I deeply sympathize with your problem. I am very much interested in restructuring that market so we break mandates and eliminate practices like exclusion of preexisting conditions.

Thank you, Mr. Chairman.

Mr. Russo. The gentlelady's time has expired.

I want to thank the panel for their testimony, and hopefully we can address those problems before the end of this session.

Mr. Russo. Our next witnesses are a panel consisting of the General Accounting Office, represented by Mark Nadel; and Lynn Etheredge; and the American Academy of Actuaries, represented by Mr. Harry Sutton.

Dr. Nadel.

**STATEMENT OF MARK V. NADEL, PH.D., ASSOCIATE DIRECTOR,
NATIONAL AND PUBLIC HEALTH ISSUES, HUMAN RESOURCES
DIVISION, U.S. GENERAL ACCOUNTING OFFICE**

Mr. NADEL. Mr. Chairman and members of the committee, I am pleased to be here today to testify concerning health insurance options and reform of the private health insurance market. My testimony this morning focuses primarily on small businesses and their employees for whom health insurance is an especially acute problem. The smaller the firm, the less likely it is to offer health insurance. About one-third of all the uninsured, almost 10 million people, work for or are dependents of people who work for small businesses, and the difficulties that these firms face appear to be increasing.

I will discuss several problems in the competitive insurance market that restrict the availability or result in higher premium prices for small firms. The first problem is the decline of community rating. In the past, companies selling health insurance used community rating in which the premium is based upon the average projected medical cost of all subscribers in a particular area or other broad grouping. Premiums do not vary within the grouping. Therefore, all firms in an area paid pretty much the same premium regardless of whether their employees were unusually healthy or unusually unhealthy.

However, as health care costs grew, commercial insurers found that they could attract businesses with relatively low-risk employees by offering businesses lower rates. But as these businesses left the community-based risk pool, the rates needed to cover the costs of serving the remaining firms rose. The ability to spread risk in

community-rated plans diminished because the remaining pool contained mainly firms of one or more high-risk employees, and community-rated insurance became less available.

With an ever-shrinking risk pool, small firms are basically experience rated. With even one or two sick employees or their spouses or children, small businesses often find that policies to cover those individuals are totally unaffordable.

A second problem is that the market is further segmented by the trend toward self-insurance. Most large employers now self-insure. These firms are being experienced rated anyway, and they calculated that they could save money by covering the risk themselves rather than paying a premium to have an insurer cover the risk.

A small firm is generally not able to self-insure because a single, unexpected, high-cost medical condition among its employees could jeopardize its financial situation.

This self-insurance trend has been furthered by ERISA, which preempts State laws and presents firms with financial incentives to self-insure, including exemptions from specific benefits mandated by State governments and exemptions from State premium taxes, which, after all, are passed on to the insuring firm, and any State risk pool contributions.

A third issue is restrictive underwriting practices. Within the traditional insurance market, small businesses face underwriting practices used by some insurers to move costly industries, firms, or individuals out of their pool. Medical underwriting often results in the exclusion of some employees from coverage if they have preexisting conditions such as cancer or other high-cost illnesses. Such individuals may be denied coverage altogether, or their specific condition may be excluded. Additionally, sometimes limits are set for particular diagnoses, such as AIDS, which could be excluded altogether or in a two-tier system could have a cap placed on specific coverage.

Some insurers do not cover industries where the risk of illness or injury appears to be greater than average. For example, high-risk industries like logging, roofing, and other such fields have trouble getting insurance, not just because of the risk of injury but because the insurer does not want to in the future get into a legal hassle over whether workers' comp covers the injury or whether the primary insurer should cover it. Additionally, physicians or lawyers may have trouble because of the fear of litigation.

Even when a firm and its workers have comprehensive health insurance, they still may be affected by their company's underwriting practices. Policies can be written for a set time, and at the end of that time, the company may subject covered individuals to new medical underwriting criteria. Also, workers who develop medical problems may face financial problems if their employers change insurance companies, which often happens. Nearly a third of insured firms either are dropped by their insurance companies or leave their insurance companies each year. And employees may then face medical underwriting.

There are other reasons why small businesses face higher costs. They face higher overhead costs spread over a small base, and they also may face the cost shifting, as the discounts available to larger

firms are not available to them and yet they have to make up those costs for the providers.

As you will be hearing later, a number of groups are proposing reforms aimed primarily at the small business market. These reforms include rating and underwriting reforms, exemptions from State mandates, and subsidies for purchasing insurance. While these reforms do hold promise, they leave some issues unresolved.

First, rating and underwriting reforms would redistribute costs among employers. Second, the market would remain segmented as most large insurers self-insure in a different financial and regulatory environment. Finally, these reforms do not address the important problem of health care costs, which is what underlies the insurance crisis.

Mr. Chairman, this concludes my statement. I will be happy to answer questions later.

[The prepared statement follows:]

TESTIMONY GIVEN BY MARK V. NADEL
Human Resources Division, U.S. General Accounting Office

Private Health Insurance: Problems Caused by a Segmented Market

Mr. Chairman and Members of the Committee:

I am pleased to be here today to testify concerning health insurance options and the reform of private health insurance. My statement today is based on both an update of a past report¹ we completed on this issue and additional ongoing work we are performing on state and state-oriented health reform initiatives.

Because of rising health care costs and resulting competitive insurance practices, there is growing concern that the continued availability of employer-sponsored health insurance is coming under pressure. Traditionally, the United States has relied on voluntary employer-provided health benefits to insure Americans under age 65. Between 1980 and 1988, however, the number of people covered by any private insurance fell by about 5 million despite employment growth of more than 15 million.

My testimony this morning focuses primarily on small businesses² and their employees, for whom the affordability and availability of health insurance are especially acute problems. The smaller the firm, the less likely it is to offer health insurance. About one third of all the uninsured--almost 10 million people--work for or are dependents of people who work for small businesses.

The difficulties small businesses face appear to be increasing. Last year, a survey by the National Federation of Independent Business found that about 19 percent of firms not currently offering health benefits had offered it in the near past.

Restricted availability and higher premium prices for small firms result from the workings of the competitive insurance market. There is concern that the competitive insurance practices and market conditions that result from rapidly increasing health care costs threaten the viability of the voluntary employer-based system. Specifically, the competitive insurance practices and market conditions that affect small businesses and their employees include:

- competition among insurers to offer coverage only to the best risks, and the subsequent decline in availability of community-rated health insurance products;
- incentives to self-insure, created by the increasing prevalence of experience-rated health insurance policies and the less stringent regulation of the self-insured, that small businesses generally cannot take advantage of;
- restrictive underwriting practices, including the exclusion of individuals (or dependents) from an insured group or excluding an individual's preexisting medical conditions, as well as insurers' refusal to renew coverage or offer coverage for certain industries and groups; and
- purchasing power advantages available to large firms, both in the amount of their health care expenditures used

¹Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting, GAO/HRD-90-68, May 22, 1990.

²Companies with 25 or fewer employees.

for administrative overhead, and in their ability to negotiate discounts with providers.

I will discuss each of these in turn.

Competition among Insurers and the Decline of Community Rating

The purpose of insurance is to transfer the risk of economic loss from an individual to an insurer. The insurer agrees to pay losses suffered by the insured in return for a premium. This agreement is possible because the insurer is able to pool the risks of a large number of insured individuals and to predict, for the group as a whole, the probable claims to be filed during a given period.

In the past, companies selling health insurance assured that premiums they collected covered claims they paid by placing all their beneficiaries into one very large group and actuarially projecting their claims. Premiums, then, would be an equalized charge across the entire group to cover the future claims costs and administration. This process is called community rating.

Under community rating, the premium is based on the average cost of the anticipated health care used by all subscribers in a particular geographic area, industry, or other broad grouping. Premiums do not vary for subscribers (individual companies) included in each grouping--companies with healthy employees subsidize the health care costs of companies with less healthy employees. Therefore, an individual firm's premium is not increased even if the firm employs individuals with health problems, nor are premiums reduced if a company has only healthy employees. Thus, community rating allows small firms, even those with an employee or employees with high health care costs, to continue providing health insurance at the same price as all other firms.

As health care costs grew, commercial insurers found that they could attract businesses with relatively low-risk employees by offering those businesses lower rates. In addition, many medium and large firms left the insurance market and self-insured--that is, assumed the risk for their employees' health care costs themselves rather than paying an insurance company to perform this role. As the businesses opting to self-insure and the firms employing relatively low risk employees left the community-based risk pool, the rates needed to cover the costs of serving the remaining firms rose. As the competing commercial insurance companies continued to siphon off the firms with the lowest expected health costs, the ability to spread risks in community-rated plans diminished because the remaining pool contained mainly firms with one or more high-risk employees. Rising health care costs and increased insurance market segmentation have made community-rated health insurance products less available. As a result, small firms with one or more high-risk employees may find policies that cover these individuals unaffordable.

Not only is the small group health insurance market smaller and more segmented, but insurance companies also are modifying the rates they offer a particular firm to reflect the age, sex, and health status of the individuals working there. The average premium costs for women in their twenties can be nearly twice as high as those for men of the same age, partly because of costs associated with pregnancy and partly because of generally higher use of services. Premium variation by age is also becoming more common. In one insurance plan in northern Virginia, for example, a company pays approximately \$135 per month to insure an individual age 29 or under, while it pays \$410 per month to insure an individual age 60 or above. Thus, firms that employ

many young women or elderly employees may find employee health insurance unaffordable.

As the risk pool of insurance purchasers has been narrowed by insurance companies competing to insure only the lowest risks, and as insurance companies increasingly base premiums on individual differences, some have questioned whether health insurance is performing its traditional insurance role. Is insurance still acting to spread risks over a pool of enrollees, or has it become merely a prepayment mechanism for health care costs?

Self-Insurance Complicates Problems in Traditional Market

The market is further segmented by the trend toward self-insurance. The rise of competition among commercial insurance companies led to the development of experience rating for large firms³--that is, a rating that bases a group's premiums on their cost experience. Given experience rating, employers with sufficient resources found that they could reduce their health care expenditures by self-insuring rather than paying an insurance company to perform this role. Most large employers now self-insure.

The reasons larger companies are more able to self-insure include their ability to spread the risk of health care costs over their large employee populations--making costs predictable--and their tendency to have stronger financial bases that allow them to absorb any potential claims irregularities. A small firm is generally not able to self-insure because a single unexpected high-cost medical condition among its employees could jeopardize its financial situation.

The self-insurance trend has been thought to be furthered by financial incentives created by the Employee Retirement Income Security Act of 1974 (ERISA). Between 1974 and 1990 the number of the nation's employees covered by self-insured firms grew from 5 percent to 56 percent. While regulation and taxation of the health insurance industry are generally state prerogatives, for self-insured firms, ERISA supersedes "all State laws . . . relat[ing] to any employee benefit plan," including health benefits. Thus, firms that self-insure are exempt from what could be costly state regulation and state premium taxes.

ERISA was originally designed to protect employee benefit rights. Its emphasis was on employer-sponsored pension plans, and it contains detailed specifications for their operation. ERISA also regulates health plans, but contains only minimal requirements for them, while state regulations for health insurance are more comprehensive.

The financial incentives to self-insure created by ERISA include exemptions from state mandated benefits (such as prenatal and well-baby care or services provided by a chiropractor), state insurance premium taxes (ranging from 2 to 3 percent of premiums), and state risk pool contributions that require assessments on insurers. In addition, ERISA does not require insurance reserves so self-insured firms are not required to have them. The self-insured firm, rather than an insurance company, receives the use of such funds, from which they can generate interest. Self-insured firms also earn interest income by paying claims as they arise rather than prospectively. Firms purchasing traditional insurance, meanwhile, remain subject to the state laws requiring particular benefits and state taxes imposed on insurance premiums.

³Companies with 500 or more employees

Although most self-insured firms cover the majority of state-mandated benefits, such firms do have the option not to offer certain benefits and they generally do not contribute to the state premium taxes or risk pools. This forces the traditionally-insured firms to shoulder more of the burden of any risk pool subsidy.

Restrictive Underwriting Practices

Within the traditional insurance market, small businesses face additional problems from medical underwriting used by some insurers to move costly industries, firms or individuals out of their pool. These restrictive practices often result in the exclusion of some employees from coverage if they have preexisting conditions, such as cancer, diabetes, heart disease or other high-cost illnesses. Such individuals may be denied coverage altogether, and in other cases only the specific preexisting condition is excluded. This underwriting also may limit the coverage available to employees' spouses and dependents.

A method used by insurance companies to limit their liability for high-cost diseases and conditions is to set limits for the total amount they will pay for selected diagnoses. Some insurance companies now sell two-tiered insurance plans. These plans divide benefits into two groups with different lifetime benefit levels. Tier 1 may have a limit of \$1 million, and tier 2 may have a lifetime limit set substantially lower. Conditions falling into tier 2 often include: mental illness, alcoholism, drug abuse, and Acquired Immune Deficiency Syndrome (AIDS)--all high-cost medical conditions.

As an example, a plan offered by an employer in Indiana is currently being challenged on discrimination grounds. This employer offered a health insurance plan to his employees which set a lifetime limit for AIDS-related care at \$50,000.

Some insurers do not cover a number of industries where, as a group, the risk of illness or injury appears to be greater than average. As examples, some insurers do not cover:

- logging, roofing or other high-risk occupations, where the concern is not only with the health care costs but also the legal expenses of determining whether workers' compensation or health insurance is to be the primary payer;
- physicians or lawyers because they believe it is too expensive to deal with fraud, abuse, and litigation for small firms in these fields;
- entertainment or sports industries because they perceive a high risk of drug abuse and their treatment costs; and
- barbers, beauticians, and decorators because they assume a high risk of AIDS and sexually transmitted disease.

Even when a firm and its workers have a comprehensive health insurance plan, they may still be affected by their insurance company's underwriting practices. Policies can be written for a set time, and at the end of that time, an insurance company may subject covered individuals to medical underwriting criteria. This practice, known as renewal underwriting, can result in exclusion of coverage for any person who has developed an expensive medical condition while he or she is insured. Renewal underwriting allows an insurance company to renegotiate its business contract so that currently existing conditions can be excluded as preexisting conditions and new policy limitations can be added on an annual basis.

Workers with preexisting conditions may face particular problems if their employers change insurance companies--a frequent occurrence. Nearly a third of insured firms either are dropped by their insurance companies or leave their insurance companies each year.

First-year costs for a small business policy are considerably lower than the costs for subsequent years because of medical underwriting and preexisting-condition exclusions. In the second and subsequent years, some preexisting condition exclusions expire and the covered population begins to develop new conditions leading to higher costs. Higher costs generate the need for rising premiums. In the face of these higher premiums, many small businesses respond by seeking a new insurer who will offer them a lower first year rate. An employee with a serious illness or even a pregnancy that began under the lapsing insurance contract may not be covered. These employees may find themselves excluded from necessary coverage under the new insurance company.

Small Businesses Face High Costs in Offering Health Insurance

In addition to the problems created by competitive insurance practices, there are other reasons purchased insurance may impose higher costs on smaller businesses. Small firms and their employees have been particularly hard hit by the general rise in health care costs. During 1988, health care costs for firms with fewer than 25 employees increased by 33 percent--a rate of increase 1 1/2 times the rate experienced by the nation's largest firms.

An important component of the high insurance costs faced by small businesses is administrative cost--the cost of administering and providing health insurance other than actual payments for medical services. Administrative costs vary among purchasers of health insurance. A Congressional Research Service (CRS) study found that smaller businesses pay a much larger portion of their premium for administrative costs than do larger businesses. Table 1 shows that smaller businesses are charged more for all aspects of administrative expenses--administration of claims, risk premium charges, and commission payments.

Table 1: Breakdown of Insurance Company Administrative Expenses
(Percentage of Incurred Claims)

<u>Number of employees</u>	<u>General^a</u>	<u>Profit & risk</u>	<u>Commission</u>	<u>Total</u>
1 to 4	23.1	8.5	8.4	40.0
5 to 9	21.0	8.0	6.0	35.0
10 to 19	17.5	7.5	5.0	30.0
20 to 49	14.9	6.8	3.3	25.0
50 to 99	10.0	6.0	2.0	18.0
100 to 499	8.9	5.5	1.6	16.0
500 to 2,499	7.8	3.5	0.7	12.0
2,500 to 9,999	5.9	1.8	0.3	8.0
10,000 or more	4.3	1.1	0.1	5.5

Source: CRS - Private Health Insurance: Options for Reform, Sep. 20, 1990.

^aIncludes claims administration, general administration, interest credit, and premium taxes.

A further advantage of large firms is their ability to use their size as market clout in negotiating discounts with providers if they self-insure. Small firms do not have the size or market power to do this. Discounts offered to large firms, as

well as the ability of Medicare and Medicaid to set provider reimbursement rates, may drive up the costs to those still purchasing health insurance, as providers attempt to make up the cost differential of the discounts.

Small firms that are unincorporated face additional higher insurance costs because of the differing tax treatment of benefits offered by incorporated and unincorporated businesses. In 1989, using an IRS classification, there were about 14 million self-employed, sole proprietorship, partnership, and S-corporation⁴ firms. Such firms are allowed a 25-percent deduction for health insurance premiums paid for themselves and their employees. Incorporated businesses, on the other hand, are allowed a 100-percent deduction for these expenses. The higher tax rate imposed on health benefits provided by unincorporated businesses contributes to the higher costs this type of small firm faces when purchasing health insurance.

ATTEMPTS AT REFORM

The problems with the small business health insurance market have been recognized by a number of groups who are initiating reforms targeted at the state level. These reforms fall into three main categories: (1) rating and underwriting reforms; (2) state mandate exemptions; and (3) subsidies for purchasing insurance.

Rating and Underwriting Reforms

The Health Insurance Association of America (HIAA), the Blue Cross and Blue Shield Association, and the National Association of Insurance Commissioners (NAIC) have recently developed packages of similar rating reforms that aim to ensure the availability of health insurance to any small business, regardless of its employees' health conditions. The proposed reforms aim to introduce predictability and stability to the small employer health insurance marketplace. These proposals include the following common elements:

- a guarantee of availability of coverage for all groups wishing to purchase health insurance;
- a ban on exclusion of coverage of any individuals who are part of employed groups purchasing insurance;
- a ban on insurance companies' imposing preexisting-condition exclusions once an individual has obtained coverage and fulfilled the preexisting-condition requirements of any plan, even if an employer switches insurance plans or an employee changes jobs;
- a requirement that insurance purchased by a group is renewable upon expiration, despite any health status changes of members of the group;
- a limit on the range of premiums insurance companies can charge similar firms and a limit on year-to-year rate increases for any particular firm; and
- a reinsurance mechanism for insuring high-cost members of a group or high-cost groups.

The Blue Cross and NAIC proposals include a recommendation for changes that would increase states' regulatory authority over their insurance markets. Greater state control would require

⁴A small corporation that elects to be taxed as a partnership for Federal income taxation purposes

amendments to ERISA so that all groups providing insurance--insurance companies and firms that self-insure--operate under state regulations. Several states, including Connecticut and Maine⁵, have already adopted components of these reform proposals.

Exemptions from State-Mandated Benefits

Within the last year, nine states passed laws allowing insurance companies to offer packages exempt from most state-mandated benefits to small businesses. State-mandated benefits require health insurance policies to cover specific diseases and health care services. Mandate exemption laws attempt to reduce the cost of health insurance for small businesses by allowing them to provide a limited benefits package.

Proposals for reform introduced by HIAA and the Blue Cross and Blue Shield Association include provisions that would allow carriers to develop lower cost products for small employers by exempting insurers in the small group market from state mandated benefits.

Subsidies for Purchasing Health Insurance

Six states have enacted legislation that authorizes tax incentives to small firms for insuring their employees. Generally, these laws establish temporary state tax credits to small firms that purchase health insurance to reduce their initial expense.

Private groups, such as the Robert Wood Johnson Foundation, have developed insurance reform initiatives that offer subsidized health insurance to make it more affordable. The Robert Wood Johnson Foundation, along with several state and local governments, funded 15 different programs designed to increase the availability of health insurance. Several of these projects provide direct subsidies to small businesses or employees of small business to purchase health insurance. Most of the projects offer new insurance through health maintenance organizations (HMOs) or tailor existing insurance packages to meet the needs of the small business insurance market.

ISSUES REFORMS LEAVE UNRESOLVED

The state and private reform efforts provide some models for Congress to consider in addressing health insurance reform. They

⁵In Connecticut, legislation was enacted in May 1990 that includes the following provisions: (1) carriers in the small group market are: required to accept all applicants for coverage, prohibited from dropping employers from coverage because of bad experience, and limited in the use of a group's own health status or experience in determining the group's rates; (2) a mandatory, private reinsurance program is established to spread the costs associated with accepting all small groups; losses from this program are financed from the small group market, first, and then from the rest of the private insured market; and (3) currently uninsured small groups (that have not provided coverage for the past two years) will be able to purchase special lower-cost products from all carriers; these products are available at a lower cost because they establish provider reimbursement at 75 percent of Medicare rates. Balance billing of insured individuals with incomes below 200 percent of poverty is prohibited.

In Maine, legislation was enacted in April, 1990, that limits pre-existing condition exclusions to two years, and requires continuity of coverage for these conditions when one group policy is replaced by another.

begin to address the access problems faced by groups that currently find it difficult to obtain insurance. The proposed rating reforms begin limiting the insurance practices that often exclude high-risk groups and group members from health insurance coverage. Mandated benefits exemptions and subsidies should lower premiums for small businesses wishing to purchase health insurance. These proposals, leave two major issues unresolved.

Rating Reforms Redistribute Costs Among Employers

First, by requiring the inclusion of high-cost individuals in group plans, the recommended reforms will cause those currently paying the lowest premiums to pay higher premiums because they will begin subsidizing high-cost individuals. Excluding more expensive individuals lowers costs for others purchasing insurance. With costs increased for some purchasers of health insurance and decreased for others, what remains unclear is how much more (or less) insurance will be purchased.

Cross subsidization equalizes the burden of health costs between the sick and the healthy. It may, however, be difficult to move from the segmented market we have now to one in which risks are spread more broadly. Some insurers have expressed concern about the transition from the segmented health insurance market to a more inclusive market. Requiring insurers to community rate could penalize insurance companies that already have larger numbers of high-risk groups in their plans. Companies now are able to charge higher rates to groups expected to be less healthy. Under community rating, these insurers would have to charge higher average premiums than insurers who now cover lower-risk groups. Therefore, they could lose their current enrollees and fail to attract new enrollees.

Also, the proposed rating reforms only address purchased insurance. While insurance costs may be reduced for some employers, those that opt out of the insurance market retain some advantages that small businesses cannot generally obtain. States and private groups are unable to resolve the difference in regulatory environment caused by the ERISA pre-emption; Congressional action would be required. Without amendments to ERISA, reform targeted on the small group market preserves the split between traditional and self-insured plans because the incentives to self-insure remain. This leaves mainly small businesses to bear the brunt of state regulation and taxation. Moreover, states remain limited in their ability to regulate and attempt reform of health benefits offered by employers.

Reform Proposals Do Not Address Overall Cost Growth

Finally, the reform efforts neither stop nor reduce the rising cost of health care. Health care cost inflation has components outside the realm of insurance reform. Even a portion of costs originating within the insurance industry--the high cost of overhead for small businesses' health insurance--is not addressed. Therefore, health insurance costs will continue to increase and firms will face pressure to drop out of the market.

CONCLUSION

In summary, the competitive workings of the insurance market disadvantage small firms wanting to purchase health insurance. Insurance companies have intensified competitive practices in order to offer lower cost plans to lower-risk groups. Large firms have responded to cost pressures by opting out of the health insurance market altogether by self-insuring. Smaller firms cannot exercise this option, and have faced health care costs that increased one and one-half times faster than the rate experienced by larger firms. Small firms also bear the brunt of both competitive insurance practices and state regulation. As a

result, it is becoming more difficult for many small firms to offer health insurance at all. The proposed reform attempts I described begin to address some of the problems of rating, underwriting and cost. However, these reforms would lead to some cost redistribution among firms in the commercial market. They would still leave a differentially regulated industry with some health benefit plans subject to state insurance regulation and taxes and others not. Finally, they do not address the need for cost control.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions at this time.

Mr. Russo. Mr. Etheredge.

**STATEMENT OF LYNN ETHEREDGE, HEALTH POLICY
CONSULTANT, CHEVY CHASE, MD**

Mr. ETHEREDGE. Thank you. Mr. Chairman and members of the committee, we don't have to go beyond the front pages of today's New York Times and Washington Post to have underscored for us the importance of making changes in our health system and of a more efficient and effective system of insurance and intermediaries.

In my prepared testimony, I cover four areas in which we can redesign the insurance and intermediary system so that it is more effective, efficient, and better serves the public. And these are areas in which Federal action can make a major contribution to improving that system.

The first area is a unified claims form and data system. I put that first knowing it risks putting people to sleep. But it is first because it is fundamental. It is the key to identifying cost and quality problems, formulating actions, and improving administrative efficiency. Whether one is a corporate benefit manager or a mayor, a Governor, or a CEO, whether one wants to improve the health system's accountability through markets or through Government action, the key is to have comparable data that can be used for all of those purposes.

We already have, in the Medicare system, a national agreement on diagnostic and procedure coding and basic data used for 40 percent of hospital discharges and 30 percent of physician services. That could easily be made the national standard and would be consistent with actions by the two leading insurance associations to move in that direction.

So what I am proposing, as a first set of actions for this committee's consideration, is a Federal requirement to standardize the reporting of health care data, and then to move from there to a system that will accumulate and analyze those data, and provide it to communities, to States, to employers, to insurers, and all those who want to improve the health system.

The second area that I suggest for your consideration is the area of medical efficacy and standards. Once we know what the problems are from the data, the insurance industry and intermediaries need to know how to apply medical science to get the best value for the dollars. Here is our country's schizophrenic position. On the one hand, we have the FDA providing perhaps the world's most rigorous clinical and scientific testing for one small part of medicine and, on the other hand, virtually no assessments going on for the vast bulk of the \$700 billion of expenditures. I think a combined public-private series of actions would work best, including the insurers, medical societies, and Government. Government can take the lead in setting up an organization that puts together a national plan to address these problems with a timetable for getting the answers that all of us need.

The third area—once the system has the data and the knowledge of what to do with it—is organizations that can act effectively. Here it is important to recognize that the United States built its

intermediary system as an insurance system. It built it through tax policy that encouraged the provision of insurance. So what we have, historically, is an insurance and bill-paying system, not a system designed to negotiate payment rates, to manage medical care, to foster competition among providers, not a system designed to restrain spending, produce useful data, assess the value of medical care, monitor patient outcomes, or change physician and hospital behavior. All those things have to be changed about our system if it is going to better serve the public.

Much of that task falls to the companies themselves and to employers in their contractual relationships with insurers and providers. But the major tool for changing our intermediary and insurance system is the \$48 billion of Federal tax subsidy, becoming \$73 billion by 1995, which now subsidizes the industry. I recommend that the committee define qualified medical plans with basic characteristics that are needed for cost containment and, over time, shift in the tax subsidies so they support only those kinds of plans. There is a precedent in the qualified pension plan area where Federal tax subsidies are now available only to plans that meet certain characteristics defined as in the public interest.

The final area is redoing the small group insurance market. We need to completely rethink how we serve this market. For 50 years, we have tried to get fringe benefits offered by small employers, and it is time to recognize that that approach is not going to work. Eighty-three percent of the employees in firms of under 25 have no pension coverage; 50 percent of the uninsured for health insurance are in firms of under 50. We simply have to have a better approach that takes the burden, as Mr. Summers was pointing out, off the donut shop owners, the gas station owners, and the drug store owners, and design a system where employees simply have to write a check and that handles the paperwork efficiently. In my testimony, I suggest how that could be done.

Finally, to carry out those policy actions, we are going to need creative thinking about Federal, State, public, and private sector roles to carry out these changes.

Mr. Chairman, if we take these four actions—to get an intermediary system that has the data it needs, knowledge about what works and what doesn't work in medical care, stronger organizations that can operate effectively and efficiently, and a market where those companies compete efficiently by serving the public rather than medical underwriting—then we will have a stronger system for the future.

Thank you.

[The prepared statement follows:]

Health Insurance Reforms

Testimony by
Lynn Etheredge

Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
May 2, 1991

Mr. Chairman and Members of the Subcommittee:

I am appearing this morning, at the subcommittee's invitation, as an independent witness. My experience related to health care financing includes nearly a decade of research and consulting with business coalitions, health insurance companies, state governments, health care providers, and others. Previously, during four administrations, I served with the professional staff at the Office of Management & Budget, as a health care financing analyst and then as staff director.

The purpose of my testimony is to suggest a broad reform agenda for the nation's health care intermediary system. Although this system is health insurance-related, it now includes many more actors than insurance companies -- self-insured employers, independent HMOs and PPOs, business coalition purchasing systems and other multi-employer arrangements, third party administrators, medical review and managed care organizations, bill audit firms, state insurance regulators, state data organizations, and others. For the private sector, this system serves about 190 million Americans and pays about 75% of consumers' hospital and physician bills.

The nation needs comprehensive reforms of this intermediary system to deal with rapidly rising costs, to assure quality of care, and to end egregious underwriting and rating practices. At current rates of increase, for example, national health care costs will be over \$1 trillion annually by 1995, and over \$10 trillion in the decade of the 1990s. If statutory reforms of the intermediary system and other measures are not enacted, we should not be surprised if such trends are realized.

In offering these suggestions for your consideration, I think they will serve well regardless of how the nation ultimately resolves broader regulatory and market-oriented cost control issues. As this subcommittee knows, the public and private intermediary systems are not separate ones -- the Medicare hospital and physician insurance programs, for example, are operated on a day-to-day basis by private health insurance companies. Strengthening major elements of the private intermediary system should prove useful regardless of whether we use taxes or premiums to funnel financing through this structure in the future.

My suggestions fall into four areas:

- uniform claims forms and billing data;
- medical efficacy and outcomes research;
- effective and efficient intermediary organizations; and
- a well-functioning health insurance market.

Acting in any one area alone will not produce systemic change. A more competitive health insurance market, for example, will not reliably improve health care unless there are better provider performance data and standards for medical review. At the same time, neither data nor medical standards will influence change unless there are also effective organizations competing on cost, quality and service to customers rather than by medical underwriting and risk selection.

Let me discuss reform priorities and potential federal actions in each of these areas:

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(1) Uniform claims forms and billing data

Once one moves beyond news stories about national health cost estimates there is a scarcity of useful data to target national cost control strategies on high price and volume increase procedures and on services with high use rate variability. Most states and communities have even more limited capacity to assess total spending in their geographic area or to identify what specific procedures and treatments, for what kinds of patients, account for price and volume increases. Today, there is a little reliable private sector data for comparing hospital and physicians charges for procedures and episodes of care, quality of care and patient outcomes. One would almost have to consult a psychoanalyst to explain why our attempts to deal with health system problems can seldom proceed rationally from the collection and analysis of objective data.

Nearly every private sector and community reform effort of which I am aware -- by large employers, business coalitions, insurance companies, health care providers, or others -- has been frustrated by this lack of basic data. Individual employer and many insurers' data bases are simply too small for reliable analyses, and aggregating data is impossible when they are not collected uniformly and treated as proprietary information. One can understand that individual providers and insurers will want to maximize incomes and seek competitive advantages by withholding information. But, as a society, we need to insist on public accountability of the health care sector so that competition is based on demonstrated performance in health care economy, quality of care, and patient satisfaction.

In addition to data limitations, the current intermediary system -- with up to 1,000 private insurers by some estimates -- is paper intensive and inefficient, with companies using different claims forms and patients (rather than providers) often being required to fill out the paperwork. It is not only patients who are burdened. AMA studies show that the average physician now employs two full time clerical and administrative personnel, compared to one medical assistant. Some analysts have made a strong case that the administrative costs of the U.S. intermediary system are so large that a government-run national health insurance program could be financed out of lower administrative costs alone.

We have long ago recognized that routine reporting of standardized data is essential in many critical areas for our private economy to function well. A leading example is the SEC-required reporting of audited financial statements by private companies, based on standardized accounting principles, which are at the heart of the securities markets. Such accurate and timely data are essential for many actors and prove useful for many purposes; the reporting standards are established by a private sector Financial Accounting Standards Board, jointly sponsored by major professional user groups of this information. These standardized data are also tools for management in assessing performance for their enterprises vis a vis other companies.

Nationally uniform data would also be philosophically consistent with President Bush's recent national testing proposals for education reform. By assuring that there are comparative data, states, communities, private payers and intermediaries can begin to establish effective accountability, a pre-requisite for improved performance.

Uniform claims forms for intermediary use, the key to an improved data system, could now be implemented rapidly. The Medicare payment system's elements -- developed through government and private sector efforts over twenty-five years -- are a nationally accepted data standard. The system is well field-tested, paying 40% of inpatient hospital expenses and some 30% of adult medical and surgical expenses.

To improve national health care data, the federal government could require these diagnostic and procedure codes and other claims information be employed as a common data set for health insurance payments. A

legislative mechanism would be to include such requirements in the "qualified medical plan" tax code standards for intermediaries suggested later, and in Medicare participation requirements. To provide for data aggregations, public reports, and analyses, basic data would also need to be reported to regional health care data centers.

To implement this concept will involve a large, ongoing job of overseeing the data system, updating intermediary requirements, and providing national, state, and community level data reports and analyses. Congress could establish a Health Data Commission with the authority to finalize reporting standards and operational details, set up regional data centers for receiving and analyzing data, prepare a national strategy for data analysis, and deal with data dissemination and confidentiality policies. The FASB model, which involves private sector user groups in standards-setting, is one approach to consider. Medicare's regional data centers may also provide useful experience for how to coordinate separate payment processes and data analysis systems. Establishing health care data centers in collaboration with university health policy research centers might be a particularly fruitful arrangement.

Over time, as "outcomes management" data technology moves beyond prototype-testing, the Health Data Commission could also require intermediaries to collect and report these data to advance state-of-the-art of medical practices, as well as to strengthen clinical performance accountability.

(2) Health care efficacy and outcomes research

For many years, the federal government, through the Food and Drug Administration, has assessed pharmaceutical products against rigorous scientific standards for effectiveness and safety. But assessing the value of health care services -- although they now account for 12% of the GNP -- is still in infancy. As a result, we have little systematic knowledge (although much opinion) about how much of the rapid increases in health care spending are worthwhile. Everyone involved in medical care, including insurer and medical review intermediaries -- but especially patients and physicians -- needs a *far* better basis for making (or reviewing) medical care decisions.

Current national efforts fall far short of what is needed to assess some \$700 billion of annual spending. The new Agency for Health Care Policy and Research (DHHS), for example, now sponsors research on only a handful of medical procedures for the non-elderly population. But I am not advocating extending government's FDA-type reviews to new medical procedures (although that ultimately might be necessary). The best way to make progress would probably be to combine forces of the medical professionals and societies, intermediaries, and government.

This seems to call for a national organization that: (1) identifies medical practice issues upon which we need better clinical information; (2) proposes a systematic national effort, coordinated among public and private sector actors and with priorities and a timetable to resolve these issues; (3) oversees this process; and, possibly, (4) makes recommendations on insurance coverage decisions and intermediary review protocols. To do this, the federal government could establish a Health Services Commission that would function, along with PROPAC, PPRC, and the Health Data Commission to perform these functions and advise the Congress. Working with this commission, the nation's intermediaries, large group practices, academic medical centers, and medical specialty societies could have a key on-going role in assessing medical practices and making them as much a science as possible.

This proposal for a Health Services Commission links to the health data strategy outlined above. Information about variations in medical practices and identifying procedures that account for expenditure growth is needed to target medical efficacy studies. Such data will also be useful to assess how well interventions affect medical practice.

(3) Effective and efficient intermediary organizations.

Historically, the U.S. built its health care intermediary system on an "insurance" model. In this model, the primary functions of intermediaries were to collect premiums, spread risks, and pay bills. Hospitals and physicians set fees; physicians and patients made medical care decisions; insurers reimbursed for incurred liabilities. This intermediary system was not designed to negotiate payment rates, manage medical care, foster competition among providers, restrain spending, produce useful data, assess the value of medical care, monitor patient outcomes, or change physician and hospital practices. Leadership insurance companies have started to change, and many new intermediary organizations such as HMOs, PPOs, and medical review firms have started up. Nevertheless, much of private health insurance still uses "blank check" payment policies and little beyond basic utilization reviews.

Federal tax policy shaped the intermediary system into this insurance model by providing generous tax expenditure subsidies for employer-based health insurance policies. This year, those subsidies will amount to \$48 billion, rising to an estimated \$73 billion by 1995. But it is now counterproductive to provide such subsidies for health insurance plans that have no capabilities for dealing with health care cost and quality issues.

The Federal government could realign tax subsidies so that they support development of a more effective intermediary system -- and stop subsidizing outdated insurance plans with inflation-perpetuating and unmanaged insurance payments. Specifically, this could be accomplished by: (1) establishing national standards for "qualified medical plan" (QMP) intermediaries; and (2) limiting the availability of income tax exclusions and deductions for employer health insurance contributions to such plans. There is legislative precedent that limits favorable federal tax treatment for employer pension contributions to "qualified pension plans" that meet defined benefit, business practice, and reporting standards.

These qualified medical plans could be required to have basic characteristics that are necessary to deal with inflated health care prices, unnecessary utilization, and poor quality of care. These include selection of providers, contractual arrangements with hospitals and physicians that include prospective payment rates, managed care programs, and quality assessment and improvement efforts. Indeed, such basic elements are already recognized as state-of-the-art among leading private health insurance companies, self-insured employers and business coalitions, HMOs and PPOs. In addition, the uniform claims forms and reporting requirements (discussed above) and underwriting and rating rules (discussed below) could also be part of these requirements.

To accelerate development of an intermediary system developed around qualified medical plans, these qualifying plans could be exempted from state laws that now restrain competitive market approaches, e.g. laws against selective provider contracting. To expand their competitive attraction to self-insured employers, QMPs also could have ERISA exemptions from state mandated benefit laws and from premium taxes.

Since most insurers will not immediately be able to meet these requirements across-the-board, it may be well to phase them in, like the auto fleet standards, i.e. in the first year, 15% of a carrier's business would need to be in QMPs for all of its business to qualify for the tax exclusion, 50% by the third year, 85% by the seventh year. Separate standards could be established for major metropolitan areas, where managed care networks are well-established, and for rural areas.

A second set of suggestions, for this subcommittee's consideration, relates to how to reduce the administrative expenses of today's intermediary system and the clinical intrusiveness of hundreds of companies involved in bill-paying and managed care.

For administrative efficiency, the federal government could: (1) require use of the uniform claims forms (described above), plus (2) require the very large number of small insurers with less than 5% to 10% market share to participate in state insurance consortia that would receive the

uniform bills from providers and make payment on their behalf. These consortia would also provide a single medical review process for these insurers. This would sharply reduce the number and variety of different billing forms, bill paying organizations, and medical review guidelines that physicians and patients have to deal with.

The federal government could also improve the intermediary system's efficiency by: (3) requiring that all insurance claims be filed directly with insurers (or the insurance consortia) by providers. This administrative procedure has been adopted for Medicare providers, which include nearly all hospitals and physicians. It is intended to increase the timeliness and accuracy of claims payment (and data), and sharply reduce beneficiary paperwork, as well as lower claims handling expenses and take advantage of electronic, tape-to-tape and machine-readable technologies.

To oversee and evolve the qualified medical plan standards, and advise on future health insurance regulation, the federal government could enact a Health Insurance Commission. This commission could also oversee the small group and other insurer reforms discussed below.

(4) Well-functioning health insurance markets

A final area for the subcommittee to consider for its legislative agenda is to improve the functioning of the health insurance markets, particularly the small group market.

The small group insurance market now poorly serves tens of millions of persons because of (a) high administrative costs, averaging 10%-40% higher than large companies; and (b) underwriting and rating practices. Much attention has focused on the latter problem, but let me start with the first problem; it may require even more fundamental reforms.

For half a century, public policy has encouraged employers to offer fringe benefits, supported by tax policy, to expand private pension and health insurance coverage. But *both* of these efforts have run aground in the small employer market. Nearly 50% of workers without health insurance are employed in firms with less than 50 workers. In the pension area, employer-offered coverage has peaked out at less than half the work force, and 83% of workers in firms of less than 25 employees lack pension coverage. We need to recognize the reality that relying on most small employers, without specialized staff, to select, offer and cope with the paperwork and complexities involved in currently offering these fringe benefits is not going to be successful.

Federal legislation could make it *far* simpler and less expensive for small employers to offer health insurance and private pensions to their workers. The arrangement I have in mind is a model where the employer only has to choose a contribution amount and write a check. Such a system (TIAA/CREF) works well nationally for colleges, universities and non-profit organizations' pensions and life insurance. Alain Enthoven has recently proposed something similar -- government-sponsored health insurance purchasing corporations organized by states or sub-state areas -- for small group health insurance markets.

Under such arrangements, the individual would sign up for health insurance through the purchasing corporation rather than through the individual employer, choose among competing plans, and retain this coverage when shifting jobs among the participating employers. The health insurance purchasing corporations would contract with competing plans, enforce underwriting and business practice standards, keep records, administer the plan marketing, and manage inter-plan competition. The employer would simply contribute a dollar amount for covered workers.

This arrangement should be much more efficient than hundreds of insurance companies marketing to thousands of employers in major market areas with high rates of employer account-shifting and employee turnover. It should eliminate much of the 10% to 40% excess administrative costs to small employers, plus reducing their paperwork and

administrative hassles. It should also be able to establish new underwriting rules and bring more managed care plans and effective competition to this market.

This administrative structure will also have important advantages, compared to employer-arranged plans, as Medicaid expansions cover pregnant women and children in working families, and low wage families seek to take advantage of the new health insurance EITC. Asking each small employer to deal with the complexities of coordinating benefits with these provisions would simply exacerbate their unwillingness to deal with health insurance coverage. This arrangement also offers major benefits to insurers if a "play or pay" system is part of national health insurance plan. It allows for capping the employer contribution, with Medicaid and EITC subsidies paid to the health insurance corporation, rather than moving tens of million of employees and their families out of the private health insurance market and into an expanded Medicaid program.

Health and pension/life insurance corporations could be separately established to serve the small group market in each area. But it might be easier for employers, workers, and insurers to combine them into "one stop shopping". Most large commercial health insurers are also in the pension/life insurance business, as are some Blues plans.

In terms of the second major small group market problem, underwriting and rating practices, BCBSA and HIAA have proposed excellent principles for regulating their current experience-rated markets, and provided extensive technical work (and intra-industry persuasion) in their efforts.

Without getting into the specifics of these proposals, which are the subject of another panel, I must raise the question of how well regulation of experience-related plans will work in the small group health insurance market.

Are state insurance regulators really going to police and enforce standards for the marketing, rating and other business practices applied by all insurance companies for the nation's myriad gas stations, drug stores, laundries, restaurants, and other small employers -- particularly when there are so many sophisticated ways to game the systems and so many insurance companies that have already shown themselves adept at doing so? The track record of state health insurance regulation is not inspiring -- as this subcommittee well knows from the Medigap market problems where state insurance regulators were remarkably ineffective even where there were clear, quantifiable, and easily verified standards. And I worry that the difficulties of obtaining industry-wide agreements bodes ill for a presumption that good citizenship can be counted on to prevent egregious behavior.

Should the subcommittee adopt a regulatory, experience-rated approach, I think the recent Medigap reforms -- with standardized insurance policies -- should also be applied to lessen insurer skimming of risk pools through marketing selected plan features. ERISA will also need to be modified so all small insurers (METs, MEWAs) are operating under the same rules.

It might be possible to integrate the health insurance purchasing corporation concept with the BCBSA, HIAA, and NAIC proposals. The health insurance purchasing corporation could be charged with assuring compliance with their suggested principles (e.g. no pre-existing conditions exclusions for individuals with continuous coverage) and could choose to manage its affairs using community rating, one of the BCBSA options, the basic HIAA arrangement (limited to the top ten insurers), or other methods. State insurance regulation could, in turn, monitor these purchasing corporations. If such integration cannot be realized, I think that the health insurance purchasing corporation is a better way to serve the small employer community, for reasons described earlier. As an active management system, which has fiduciary responsibility, money on the line, and the ability to deal with bad actors by summarily kicking them out

in favor of better performers, I suspect it will also work better than market oversight by regulators of experience-rated insurance.

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As this subcommittee deals with how to make a ban on pre-existing condition exclusions for continuously insured individuals a standard for the small group insurance market, it may also wish to legislate such requirements broadly. The recent *New York Times* stories make it clear that such practices are now part of the large employer market, giving rise to growing public anxieties, reducing willingness to change jobs, and interfering with the nation's labor markets. Adding such standards to the conditions for a tax-subsidized qualified medical plan would be one way to effect such reforms.

In conclusion, Mr. Chairman, with federal legislation -- to develop uniform claims forms and billing data, medical efficacy standards, effective and efficient organizations, and better-functioning insurance markets -- the nation can have a stronger intermediary system with a key future role in American health care.

Mr. Russo. Thank you very much, Mr. Etheredge.
Mr. Sutton.

**STATEMENT OF HARRY SUTTON, VICE CHAIRMAN, HEALTH
ISSUES COMMITTEE, AMERICAN ACADEMY OF ACTUARIES**

Mr. SUTTON. Mr. Chairman, members of the subcommittee, I am pleased to be here representing the Academy of Actuaries. I will speak rapidly so I can get a few of my points across.

It might be helpful to know my background. I worked for a very large insurance company many years ago, including their small group business. I was a consultant to the HMO industry for 15 years. Now I am in the reinsurance business covering catastrophic claims for HMO's.

We all have the objective, and the academy agrees, that some changes have to be made in the small group area of the insurance system. But I would like to make two major points: First—and I think it has already come out here—the cost of health care as we know it today is essentially unaffordable for lower income individuals and many smaller employers. The reason we have the frequent changing of carriers and the various rating systems used for small group health is because most small employers can't afford health insurance. But a few of them, if they are underwritten carefully, can get lower rates. Therefore, they move from one company to another.

In a sample done by the University of Minnesota of uninsured individuals in Minnesota, 83 percent of them said they could not afford coverage; 7 percent said they didn't need it; 2½ percent said they were uninsurable. These were the more or less permanently uninsured. Those that were intermittently uninsured had similar results. But most of the intermittently uninsured lost their insurance and couldn't afford to pay for it between jobs.

Second, I want to point out that one of the big consulting firms has estimated that the average cost of health insurance per employee for very large employers in 1991 is \$4,100 per year. I think you can see that somebody with a salary of \$15,000 or \$20,000 can't afford to purchase it out of his own pocket. The reforms that we are talking about in the small group market—limiting underwriting, limiting preexisting conditions limitations, and moving toward community rating—will raise the average premiums for many of the small employers who already buy coverage. The fact is they can't afford it.

So what few things would we recommend that should be integral to any legislation that might help attack the problem? One would be to create more affordable coverage. Now, there are a few things that might do that. First, get rid of all the State mandates and permit low-option benefit plans. I work a lot with State legislators. If you look at Massachusetts and their universal health bill, it required every mandated benefit to be included. We found they were unaffordable, and now there's a bill in Massachusetts that would cut the benefits back.

We also need an emphasis on managed care, and any legislation should prevent States from limiting the use of managed care or provider networks and should encourage the development of

HMO's. However, HMO's need to offer, and be allowed to offer, lower cost benefit plans because HMO plans are very benefit rich. You might look at the Washington Basic Plan offered by Group Health of Puget Sound as an example. Another way, though minimal, of lowering the cost of health insurance would be to eliminate premium taxes on small employer groups, which is worth a 2 or 3 percent savings.

One other item which is really a background to the problem of the small employer and the individual purchasing coverage is the concept, mentioned in our written testimony, called selective disenrollment. Ours is a voluntary insurance system, and at any time the price of the product gets too high, the individual does not have to buy it. Therefore, what has happened is that a lot of people have decided to go bare because they don't want to spend the \$2,000 or \$3,000 to insure their family. That is not only employers, but the individuals who have to pay contributions. Small employers very often pay a minimal amount, such as half the single employee premium, and the employees may have to cover their dependents by paying a couple hundred dollars a month. Not surprisingly, many decide not to cover their dependents because the cost is too high compared to their income.

So one of the things that we think in examining this issue in Minnesota and other States is that lower income people who need individual coverage and small employers, particularly in the service industries where wages are low, will have to have some kind of a subsidy from taxes, whether it is State or Federal. Otherwise, many people cannot afford coverage. They simply will not spend 20 or 30 percent of their income to buy coverage.

I should mention, with reference to one of the bills that you talked about before (HEART), that most insurance companies will not issue a contract to any employer without the employer paying a good part of the premium.

One last thing. If you are going to reform the small group health insurance market—and there should be changes in underwriting—you also will need to regulate MEWA's, that is, self-insured multiple employer trusts. Reform could very well fail if all players are not regulated and forced into whatever system is developed.

I would be very happy to answer any questions about the testimony, and I apologize for rushing through this complicated subject. Thank you.

[The prepared statement and additional information for the record follow:]

AMERICAN ACADEMY OF ACTUARIES

SUBCOMMITTEE ON HEALTH
 COMMITTEE ON WAYS AND MEANS
 U.S. HOUSE OF REPRESENTATIVES
 HEARINGS ON
 HEALTH INSURANCE OPTIONS:
 REFORM OF PRIVATE HEALTH INSURANCE

TESTIMONY
 BY THE
 COMMITTEE ON HEALTH
 AMERICAN ACADEMY OF ACTUARIES

May 2, 1991

The American Academy of Actuaries is a national professional organization formed in 1965 to bring together into one organization actuaries of all specialties within the United States. In addition to setting qualification standards and standards for actuarial practice, a major purpose of the Academy is to act as a public information organization for the profession. Academy committees regularly prepare testimony for Congress, provide information to congressional staff and senior federal policy makers, comment on proposed federal regulations, and work closely with state regulators on issues related to insurance.

This testimony was prepared by the Academy's 16-member Committee on Health. The committee is made up of representatives from the entire range of health actuarial practice. The committee includes actuaries who work as consultants, are employed by insurance companies, are actuaries for government health programs and state insurance departments, and are employed by nonprofit health organizations.

INTRODUCTION

The first part of this testimony briefly describes the development of private health insurance in the United States. This discussion is in response to the Subcommittee's request for background on how the private health insurance system got to where it is today.

The second part of the testimony addresses possible changes that could be made to the private health insurance system to expand access to health insurance and make private health insurance more affordable. In responding to the Subcommittee's request for suggestions in this area, the Committee on Health has limited its comments to the health insurance marketplace for small employers.

The current high cost of medical claims and increases in these costs that consistently outstrip increases in other costs are of grave concern to all employers. However, the impact of high medical costs has been most seriously felt in the small employer insurance market. Although employer-sponsored health insurance coverage among small employers has always been much less universal than among larger employers, there are indications that fewer small employers may be providing health insurance than in the recent past. Moreover, rising claim costs and the demand by small employers for more affordable health insurance has led to almost revolutionary changes in insurance practices in the small group market.

These new practices have made health insurance more affordable than would otherwise have been the case for the healthier small employer groups. However, lower premium rates for carefully selected healthy small groups have come at the expense of much higher rates for older groups and groups that include less healthy individuals, or those employed in industries with higher health risks. The results have been apparently widespread differentials in premium rates among small employer groups. These widening differentials have become the foremost concern of both state and federal policy makers who view this development as a major obstacle to access to health care for an increasing number of working Americans and their dependents.

A BRIEF HISTORY OF PRIVATE HEALTH INSURANCE IN THE U.S.

In the 1800s there was no organized health insurance system in the United States. In fact, there was almost no organized delivery of medical care. Health care was largely viewed in terms of personal treatment by private physicians. Hospitals, which were frequently financed by donations from the wealthy, were maintained largely to provide comfort to those dying of illnesses, often indigent.

During the first quarter of the 20th century, there was a major restructuring of the training for physicians and more expensive hospital systems were developed. As the health care system grew, doctors received better training and the cost of health care became more understandable; it was a natural development to seek systematic financing methods rather than to rely solely on charity, welfare and individual resources.

Although there were group insurance-type contracts covering life insurance in the early 1900s, there were very few products for medical insurance. In 1927, a major breakthrough in health insurance occurred with the development of the first Blue Cross program covering Baylor University in the state of Texas. Within a 10-year period, almost every state had its own Blue Cross plan. These state-chartered, not-for-profit plans insured hospital costs. Soon after the development of Blue Cross plans, state medical societies sponsored similar legislation to create what were known as Blue Shield plans to provide coverage for physician services—specifically in-hospital medical visits and surgical procedures. Later, many of the Blue Shield plans linked together for marketing and administration with Blue Cross plans, although a number of them still function separately throughout the United States today.

Initially, the plans were largely controlled by hospital and medical providers. Blue Cross/Blue Shield contracts were sold to individuals, although often with the sponsorship of major unions or employers, and, frequently, the premiums were paid in full by the employee. In the early years, the premiums were as low as 50 cents per month per individual and \$1.00 per month per family.

For many years, the programs functioned much like HMOs. Almost all of the risk of the premiums being inadequate to pay claims was passed on to the providers. Thus, most contracts with providers agreed that payment would be pro-rated to live within the premium income developed by the health plan. Unlike HMOs, however, the early Blue Cross/Blue Shield plans did not provide for utilization controls and permitted differentiated patterns of practice.

As time passed, the plans became more independent of the providers, and the providers pushed to eliminate any risk to them of not obtaining the full amount of contractually agreed upon reimbursement rates. Today, many Blue Cross/Blue Shield plans no longer are controlled by providers, and on most boards, providers are usually the minority.

During the 1930s, major life insurance and casualty companies experimented in the health insurance field. Many commercial insurers offered individual coverage. Moreover, because there was almost no health care inflation during the 1930s and hospital wages and physicians' fees remained relatively stable, the products offered often promised a level premium for life. Despite the entrance of commercial carriers into the market, the Blue Cross and Blue Shield plans remained predominant and, at the end of the decade, the Blues had between 80%-90% of the total market.

The advent of World War II resulted in tremendous changes in health insurance and other employee benefits. Although wages were strictly controlled, the federal government passed laws permitting employers to provide benefits in lieu of wage increases. The government felt the cost of increased fringe benefits would be low enough so as not to disrupt the national economy during the war. At this time, and shortly before the war, many major U.S. corporations such as General Motors, General Electric and others were permitted to bargain for benefits with their unions, and benefit programs became a business deductible expense for the employers and non-taxable income for the employees. (This development, while momentous at the time, ultimately may have contributed to some of the complications in health care policy which persist to this day.)

As the market for employer health insurance expanded dramatically during and following the war, the government also financed the construction of hospitals through the Hill-Burton Act and subsidized the education of an increased number of physicians through grant programs at medical schools and universities. The concomitant development of expanded payment mechanisms, together with a tremendous increase in the number and sophistication of hospitals and physicians, allowed health care utilization to expand rapidly during the 1950s and 1960s with only modest increases in the cost per unit of service.

A second great impetus to the explosion in aggregate health care costs was the enactment of Medicare and Medicaid in 1965. These programs now pay for approximately 40% of total U.S. personal health care expenditures.

With the seemingly inexhaustible financial support of major employers, as well as the federal and state governments during the 1960s and 1970s, the health care industry was encouraged to expand, modernize and conduct major research efforts which increased the cost and sophistication of health care.

Meanwhile, major changes were occurring in the health insurance markets. Originally, the Blue Cross/Blue Shield plans had used the simplest community rating. However, the commercial insurers who entered the market later were much more familiar with actuarial techniques and were able to project levels of medical claim costs using characteristics such as age, sex, and health status. Since insurance companies started with individual coverage following many years of experience with life insurance and disability insurance, it was natural for them when entering the group health insurance market to underwrite and base premium rates on the demographics of employer groups. The commercial carriers also developed experience rating, which eventually resulted in different rates for different groups based on the group's own utilization experience. The pressure of competition from the commercial insurance industry forced the Blue Cross and Blue Shield plans to abandon their community rating system, particularly for larger groups. For individuals and smaller groups, the community rating system for insurers persisted longer, and still exists in some areas of the United States today.

Commercial insurance companies continued to refine their underwriting systems for larger groups. As the larger employer market became saturated, the companies started writing smaller and smaller groups. Since the claims experience of any single small group was not statistically reliable, commercial carriers developed what is called "book" or "manual" rates which were based on the age/sex characteristics of the individuals to be insured, as well as other characteristics such as income level, geographic area and occupation. The carriers already had considerable experience with these factors in developing rates for life and disability insurance.

During the 1960s, some major insurance carriers decided to make a dramatic move into the small group market. The advent of the computer age greatly simplified marketing, administration and the development of rate proposals for widely varying small groups. Companies like Prudential Insurance Company of America set up a separate line of business, administered in one office, to concentrate the administrative functions of the small group market. At that time, it was thought that frequent small increases in rates could be absorbed by the small group markets, without the need to worry about competitors snatching small group customers away from the insurer following a modest rate increase.

Currently, insurance carriers use state licensed trusts as a vehicle for providing health insurance to small employers. The purpose of the state trust is to avoid issuing complicated group contracts to very small employers and to simplify administration. During the late 1960s and the 1970s, the industry had experimented with multiple-employer trusts that were marketed by independent agencies. These earlier trusts were supposed to be a conglomeration of small groups with limited individual underwriting and major pooling and lowering of administrative expenses. With the exception of ratings for industry and occupation, all individuals enrolled for the same benefit plan had a rate based on age and sex. These were fully pooled rates in the beginning, much like the community rating by class frequently used by HMOs, but without any control on cost.

As the U.S. embarked on a period of seemingly interminable high medical cost inflation, the multiple employer trusts set up for specific industries, or often merely to provide access to insurance for a wide variety of small employers, ran into severe financial problems. The insured multiple employer trust with an independent administrator was determined to be unworkable in its original form, and many of the major carriers refused to continue on that

basis. In response, the carriers set up their own competing mechanism to market, administer, pay claims, and re-rate small employer groups on a mass basis. With control over marketing and underwriting, this carrier system seemed to work adequately for a period of time.

The end of this type of operation came in 1980 or 1981 when there was a confluence of rapid health care inflation, a severe recession, and a recognition by small employers that health care costs were becoming too expensive to insure. At the beginning of the 1980s, the developing computer sophistication of the insurance industry, combined with the fact that health insurance costs were rapidly increasing beyond the reach of small employers, resulted in tightened underwriting, extension of pre-existing condition limitations, and the myriad re-rating formulas based on claim experience or health status of employees in small groups.

At this time, many larger insurance carriers decided that they could no longer run a profitable health insurance business for small groups by continuing their methods of operation. Many carriers ceased marketing individual health insurance and exited from the market for the smallest groups (fewer than 25 employees). As a result, there sprang up a small but significant cadre of smaller insurers who concentrated on the small employer market almost to the exclusion of large groups. These carriers, seeing a market niche, developed sophisticated underwriting and re-rating analysis systems which are causing today's concern regarding growing premium differentials and instability in the small group market.

As the insurers changed their practices, Blue Cross plans also were forced to change. By state law, some Blue Cross plans are required to have community rates or open enrollment. These plans have become the carrier of last resort for some smaller employers. Other Blue Cross plans have changed their corporate philosophy and begun underwriting smaller employers with re-rating systems similar to those of the commercial insurance companies that specialize in this field.

The HMO industry has been, and continues to be, a fairly insignificant actor in the very small group market, with most HMOs having only a minor market impact in the small employer environment. Some HMOs underwrite, but most are precluded by federal or state law from using experience rating methodologies. The ability of carriers to reduce initial claim costs by 40% or more through underwriting and initial limitations on pre-existing conditions has overwhelmed the savings from managing care. Moreover, since most HMOs do not underwrite or are precluded from doing so, the HMO industry has limited its activities in the small group market to avoid potentially severe financial losses due to adverse selection.

There is one other element in the health insurance marketplace that needs to be discussed. In the 1960s, as medical costs had grown and large employers were now beginning to worry about the cost of their health benefit plans, self-insurance evolved. These were difficult years for the insurance carriers, and many of them initially refused to participate in such programs. Even though experience rating was almost universal for large groups, many carriers seemed to believe that eliminating risk-based premium rating systems, would create a major division in the health insurance marketplace and disrupt even the limited pooling of risks across large employers.

The early self-insured programs for larger employers were done for two primary reasons: First, to avoid state premium taxes which added 2%-3% to the employer's cost and, second, to avoid contributing capital to insurance company reserves. In self-insurance arrangements where the employer only hires the insurance company to pay claims, the contracts revert to a cash flow basis, which produces a one-time reduction of 20% to 30% in claim costs. This means that the insurance carrier no longer needs to hold substantial claim reserves (typically equal to 25% of annual claims payments). Thus, this capital became available to the employer for other investment purposes. Of course, the employer then had to assume the liability for all claims during a plan fiscal year.

After the advent of ERISA in 1974, it was ultimately determined that state insurance regulation could not interfere with self-insured employer plans. It would seem that this was not a major objective of ERISA, which was passed primarily to protect the funding of pension obligations. Nonetheless, when employers started to become concerned about the rate of growth in their health care expenditures, the ERISA preemption permitted them to modify their benefit plans in ways that insurance carriers could not, since the carriers were under the regulation of state insurance departments and subject to the restrictions of state legislatures in passing laws that required increases in insured benefits--so called mandated benefits.

As indicated above, the experience of carriers with independent multiple employer trusts was severely negative, and most of the major carriers withdrew from the insured support of that market. With the development of free-standing claim administrators (third party administrators or TPAs), there developed the so-called self-insured multiple employer trust or MEWA. Since these programs were self-insured, they, too, were neither regulated by the federal government nor by the state insurance departments. Consequently, many entrepreneurs set up these programs and aggressively adopted the same underwriting standards and other practices of the small group carriers. Long-term functioning and solvency of MEWAs is often much in doubt due to a lack of auditing standards and inadequate rating systems of the smaller entities. In any attempt to restructure the small group marketplace, carriers must all be required to change their approach to the marketplace, and MEWAs must be legally required to conform to whatever practices affect the insurance industry. Otherwise, there will be an escape route that will undermine the effectiveness of any new regulation.

Currently, the overall market for health insurance is divided into four major pieces, which vary in size, depending on how classify self-insured employers are classified. When classified by carrier risk, the commercial insurance companies and the Blue Cross/Blue Shield plans each cover 50% of the traditional insured market in terms of dollars of claims. HMOs share of the market is nearly equal that of Blue Cross/Blue Shield or the commercial carriers organizations when HMO premiums are measured in terms of claim equivalents. However, the insurance companies, Blue Cross/Blue Shield plans, and independent TPAs administer a large volume of self-insured business, and in 1987, self-insured health coverage accounted for nearly 50% of the total health insurance marketplace. Moreover, it is difficult to estimate accurately the premium equivalents for Administrative Services Only (ASO) business administered by the major insurance carriers, Blue Cross/Blue Shield plans, and independent TPAs. For some of the largest insurers, ASO business may be 75% of their total premium equivalents! With such extensive self-insurance, ERISA pre-emption, which protects self-insurance from regulation, is a serious potential obstacle for many proposals that would purport to restructure small group insurance.

RESTRUCTURING SMALL EMPLOYER HEALTH INSURANCE

The Academy's Committee on Health assumes that the objective of the Subcommittee is to promote much wider availability of affordable coverage for smaller employers, thus reducing the number of uninsured individuals throughout the United States. If this objective is to be achieved within the context of a voluntary private health insurance system, it is essential that the Subcommittee understand two fundamental points.

First, although access to insurance coverage is a major and continuing concern for small employers, the major reason why small employers do not have coverage is that the employers and the individual employees who must contribute to the premiums cannot afford the current cost of health care. This is demonstrated in a recent survey done by the University of Minnesota involving personal interviews from a stratified sample of uninsured individuals in the state. Of those uninsured for the prior year, 83% indicated the insurance was too expensive and 7% that they did not need or want health insurance. Only 2.5% indicated that they were refused coverage because of poor health. Similar responses were received from individuals who were uninsured only part of the year, with the major difference being that they were not insured because they had lost their job or did not have coverage through employment. Since many of the individuals interviewed who had lost their jobs could have continued under COBRA or health insurance conversions, it would seem that the majority still did not buy coverage because it was too expensive. The cover page and page 20 of the Minnesota survey are attached as Appendix A.

The second vital point is that, if major small group reforms are implemented which adequately address many of the concerns regarding access to health insurance, it is highly likely that all carriers' premiums for small group health insurance will increase, possibly dramatically. Assuming a voluntary market is retained, this means that even fewer people in small groups are likely to be covered than are covered now. Since the majority of the people without coverage are uninsured because of the costs of health care, even if there is not a substantial increase in small group premium rates, the number of people uninsured may not significantly change, merely by mandating access through restricting underwriting and curbing other practices.

Over the past year there have been continuing developments in the area of reforming small group insurance. The National Association of Insurance Commissioners (NAIC) as well as several states have already taken action in this area. In addition, a number of other organizations have developed their own proposals for small group health insurance reform. The discussion below does not focus on any specific proposal, but rather briefly describes the major types of changes the Committee on Health believes the Subcommittee should consider and discusses a number of issues that are fundamental in order to maximize the effectiveness of any proposed regulatory changes. At the Subcommittee's pleasure, members of the Academy would welcome the opportunity to discuss in greater detail particular proposals for reform or the points made below.

In the discussion that follows it is assumed that, if reforms are adopted, they will be structured so as to preserve the current voluntary nature of employer-sponsored health insurance coverage. Were coverage of all workers to be mandated, additional issues would need to be considered and certain of the comments below might no longer be applicable.

Improving Affordability

Since the primary impediment to expanding small group coverage is high premium rates and the cost to the smaller employer, any proposal to restructure the small group health insurance market must facilitate the offering of lower cost plans by all types of carriers. Actions that would assist in accomplishing this objective are as follows:

1. Permit all carriers to offer small groups more limited insurance coverage that would exclude state mandated benefits. State mandated benefits may inflate insurance costs by as much as 20 to 25 percent. Permitting the exclusion of these benefits does not mean that these coverages are not desirable; it merely means that basic coverage is more of a necessity until the employer is large enough to afford more complete coverage. Mandates include reimbursement of particular paramedical personnel, such as chiropractors or licensed social workers for mental health, as well as specific services. These can increase costs sharply. For example, many large employers have 10% to 20% of their health costs for treatment of mental conditions or alcoholism. Unlimited use of chiropractors can increase costs by 5%.
2. Preempt state legislation that prevents indemnity plans from contracting with networks of cost-efficient providers and from requiring utilization review. Health plans of all types should be as cost-efficient as possible. Laws that impede this objective without having compelling social purposes should be removed as obstacles.
3. Eliminate premium taxes on small employer groups. This is already being considered by some states as part of small group health insurance legislative reform.
4. Encourage HMOs and other types of health care service organizations that control utilization and cost while assuring good quality. This could include permitting HMOs to offer lower benefit plans or exclude certain types of benefits that they normally are required to offer under state or federal law. An example the Subcommittee might consider examining is the Washington Basic Plan offered by the Group Health Cooperative of Puget Sound.
5. Provide funds to subsidize lower income families and low wage employees. To make real inroads with lower income families and employers with low income workers, it would seem imperative as an ultimate step to provide funds to subsidize these individuals or employers. Such funds might be provided through local taxes or federal taxes but not through additional taxes on health insurance in general because this would only raise premium rates.

Individually, most of these measures would lead to only small reductions in premium rates for small employers. Collectively, however, they could result in substantial premium cuts. This would be especially true if lower benefit packages and public subsidies were combined with other measures.

The committee believes that one final item requires comment, even though it does not relate specifically to small group reform, but rather to changes in the incentives for all employer-based coverage and benefit plan design. Studies by Rand and others have shown that more

extensive coverage promotes increasing use of health services, many of them presumably not necessary. The tax exemption to the employee of employer contributions for health care creates artificial demands to improve health benefits at no presumed cost to the employee. Consideration of taxing employer contributions to discourage excessive transfer of health costs to the employer because of tax deductibility to the employee should be seriously considered. Some members of the Academy Committee on Health believe that the removal of tax deductibility of employer health contributions would result in lower benefit plans and, hence, would indirectly lower utilization and underlying costs. Nevertheless, to expand the willingness of small employers to purchase basic health coverage, we need to retain simplicity and realistic financial incentives.

Providing Better Access

To create a stable marketplace for small group coverage and to offer long-term protection to small employers, proposals for restructuring must address:

1. Rate stability. This ultimately means eliminating many of the complex rating systems currently used which are based on health status or claim experience for very small groups. The purpose of restricting and eventually eliminating these practices would be to begin to narrow the differentials in premium rates among small groups. A number of proposals have already been put forth to begin the process of eliminating certain underwriting practices and narrowing rate differentials.

It is important to note here that in the short-run reducing rate differentials would accelerate the rate at which premiums are increasing for many small groups. In the current inflationary environment, small employer base premium rates are rising by 20% to 30% a year. If rate differentials were restricted, the small employer groups with the lowest premium rates would initially experience increases in premiums that would exceed the current 20-30% trend. Groups with the highest current premiums would initially experience premium increases somewhat below current trends. The ultimate average premium for all small groups would depend upon the extent of selective disenrollment, which is discussed below.

2. Guaranteed continuation of coverage. All employees covered by a small group plan should be guaranteed continuity of coverage not only with the employer's existing carrier, but also if the employer chooses to change carriers.
3. Guaranteed access to coverage for all small employers and all of their eligible employees. This will be a difficult goal to achieve. Among the issues here are: (1) defining who is an eligible employee (Are part-time workers in or out of the plan? Can the employer decide?) and (2) providing some mechanism for protecting individual insurance carriers against randomly acquiring a disproportionate share of unhealthy risks.
4. Guaranteed access of new employees to an employer's existing plan. If the employer provides a health insurance plan, there must be access to coverage to new employees who are entering the labor market for the first time, who are returning to the labor force, or who are changing jobs.

There is no shortage of proposals that purport to the accomplish the four objectives outlined above, and nearly all of the proposals that the Committee on Health has reviewed have some merit. Moreover, over the past year, the primary differences between proposals for reform of small group insurance have become more a matter of degree than of basic approach. Therefore, rather than discuss specific proposals, the committee focuses below on a number of fundamental issues that must be carefully considered before implementing regulatory reform within the voluntary insurance system.

Fundamental Issues Underlying Restructuring Small Group Insurance

1. Including all providers. One of the fundamental problems that must be resolved before the small group insurance market can be restructured effectively is how to assure that all insurers are subject to the new rules. If all insurance carriers are to be required to accept all applicants and have limited ability to vary premium rates, it is important that state regulatory authorities have control over all entities underwriting small group. Assuming that the state can regulate Blue Cross/Blue Shield plans, insurance companies, and HMOs,

then the only real gap that remains is MEWAs who are frequently self-insured (often with catastrophic or stop-loss coverage through an insurance carrier). If these MEWAs or MET programs are exempt from regulation, many small employers whose employees are younger or have fewer medical impairments will take the risk of becoming self-insured at a low premium rate. This will distort (i.e., increase) rates in the regulated marketplace. Bringing MEWAs under state regulation is extremely important to accomplishing effective reform and, as we understand the issue, will require action at the federal level.

2. **Reinsurance:** If carriers must accept all groups, be subject to limitations on rate variations, and be unable to terminate coverage, except when the carrier decides to withdraw totally from the health insurance marketplace, then some sort of reinsurance pooling arrangement may be absolutely necessary to facilitate widespread carrier participation in the small group market. Note that reinsurance will not lower aggregate costs! Reinsurance merely redistributes costs between carriers. The reason for some sort of pooling is to equalize the distribution of high cost individuals between carriers. In fact, aggregate costs would be expected to rise. If the pool were not subsidized by public monies, insurers' premium rates would have to be loaded to cover their expected assessments to support the pool.

Although a number of different approaches to pooling high risks are possible, there is one which has not been widely discussed in proposals to date. Twenty-two states currently have pools for the uninsurable, although many of these pools have very few members. There are some negatives to a state uninsurable pool, including limited coverage, slightly higher premium rates than a standard risk, and the possible stigma of being included in such a pool. Nonetheless, it would be very possible for the carriers to transfer their highest-risk enrollees in small groups to state pools, which would eliminate the administrative need for setting up complex pooling arrangements between large numbers of carriers. There may also be other advantages. Minnesota, for example, has all of the members of its uninsurable pool in a managed care PPO-type of plan.

Despite some advantages, funding needs to be found to finance the losses of a state operated pool for uninsurables. Currently, some states with pools tax health insurance premiums as a means of financing the pool's losses. Other states finance their limited pools out of general state revenue. However, if the losses in the uninsurable pool are added to health insurance premiums to cover the deficits, then the average health insurance premium will rise, possibly defeating the affordability objective. States and the federal government should at least consider subsidizing high-risk pools. Such subsidies would enable carriers to offer somewhat more affordable premium rates. Currently, almost all pools only permit coverage of individuals, although the pools could easily accommodate individuals in small groups or even the whole group.

When considering how to finance high risk groups, there is also the question of whether small employers alone should subsidize the pool or whether a broader scheme that taxes all employers, including the self-insured, should be used. The most appropriate method for financing pools is likely to become a more difficult issue for policy makers as more employer groups find ways to self-insure. Premium taxes will become increasingly burdensome for those that do not self-insure if the percent of those in insured arrangements continues to shrink as rapidly.

3. **Transition Issues:** A third fundamental issue is how best to implement any restructuring to minimize any serious short-run disruptions to the small group health insurance market. Although the changes enumerated above may be desirable, the health insurance market is extremely complex, and private insurance currently covers some 70% of the U.S. population. To minimize market disruptions, which the committee believes could be very serious, changes in the small group market should be incremental and evolve over a period of time. While we might wish to have all employees covered under private insurance, it will take many years to reach this goal without a mandate of coverage from the federal government or subsidies to make the premiums affordable to small employers and lower income individuals. To minimize market disruption, it would be best if certain types of transitional changes could be agreed upon and that as progress is observed in expanding coverage or access, that further changes should be expected. At a minimum, a five-year transition would be required to create a marketplace that minimally meets the basic objectives set forth above. During the transition two issues will be of particular concern if disruption of the market is to be avoided:

- a. Pre-existing conditions limitations: Presumably, the ultimate objective is to get nearly universal coverage of employers with no limitations on coverage due to pre-existing conditions. However, in the absence of universal employer coverage, if limitations of pre-existing conditions are not permitted for people who have not been recently insured, it is clear that the average premiums offered to small employers will increase dramatically. For example, in one state uninsurable pool where individuals could purchase coverage for pre-existing conditions, those purchasing pre-existing conditions coverage had first year costs nearly 10 times the average for all other uninsurable people in the pool.

In a voluntary insurance market, it does not seem feasible to permit individuals to enroll and be covered for expensive medical services immediately for a pre-existing condition. The pre-existing condition limitation will force individuals to buy coverage prior to becoming impaired or to remain uninsurable in the short-term as in the current system. A number of proponents of reform, many of whom have spoken before the Subcommittee, have indicated that all efforts to restrict coverage for pre-existing conditions should be eliminated. Most members of the Academy committee feel that maintenance of pre-existing limitations during a transition period is a necessity to avoid major disruption in the small employer marketplace. At a minimum, premiums would rise dramatically, and in the committee's opinion, very likely produce a reduction in coverage levels, rather than improving access.

- b. The rate at which premium differentials are reduced. A major objective of every serious proposal for restructuring the small employer health insurance market is to narrow the range between prices of health insurance offered to different small employers. A number of proponents of small group reform have even argued for immediate community rating to eliminate all differences in premium rates. A rapid move toward a community rate in a voluntary market might well be more disruptive than any other single change that could be made. Moreover, the disruption to coverage would very likely affect more of the 50% of Americans with private insurance who are members of small groups. Community rating would mean that insured groups who have low premiums because of age characteristics would have dramatic increases in rates. Older groups would have their rates greatly reduced. Employers with older employees would rush to become covered at the community rates and younger groups would be inclined to drop coverage.

This is not mere speculation. Selective disenrollment by individuals is by now a well-known and an often observed phenomenon. During periods of rapid health care inflation, when premium rates rise sharply, and during recessions, those most likely to drop their insurance coverage are the younger employees and lower cost groups. The movement out of coverage of these groups accelerates the premium increases experienced by other groups. This phenomenon is easily observed in closed groups such as MEWAs. There is no reason why community rating would not result in heavy selective disenrollment. Hence, community rating would be extremely disruptive, since most insured groups would have to have premium rates raised substantially. Moreover, there are a number of reasons why at least some rating parameters should be permitted, particularly in a voluntary system.

4. Government Subsidies: Regardless of the particular proposal, providing greater access to private small group insurance almost certainly will raise the average premium rates for most small employer groups, possibly substantially. If, as we narrow rate spreads, the higher rate levels cannot be offset by lowering benefits, then the objective of enrolling more small groups and reducing the number of uninsured may not be met without direct government subsidies to make the premiums lower. Subsidies are likely to be particularly important for lower income families and employers of low wage workers. Without substantial subsidies, it is unlikely that widespread private insurance coverage for these groups will be forthcoming.

APPENDIX A

COVER PAGE PLUS EXCERPT OF PAGE 20 AND TABLE 9
FROM THE
MINNESOTA SURVEY OF THE UNINSUREDCover Page

Who Are the Uninsured in Minnesota

Preliminary Report to the Minnesota Health Care Access Commission

Nicole Lurie M.D., M.S.P.H.

Michael Finch, Ph.D.

Bryan Dowd, Ph.D.

August, 1990

Division of Health Services Research and Policy, University of Minnesota School of Public Health, and the Department of Medicine, Hennepin County Medical Center, University of Minnesota

Page 20 and Table 9Reasons for uninsurance

Among these uninsured all year, the majority (83%) of those interviewed stated that they were uninsured because purchasing insurance was too expensive. Slightly over 7% stated they did not need or want insurance. This included those who stated they did not purchase insurance because of religious beliefs about health care. Only 2.5% stated they were refused health insurance because of poor health. Among those who were intermittently insured over the prior year, slightly over half stated that insurance was too expensive, and about 30% said they were uninsured because they lost a job that had provided them with insurance. Table 9 presents reasons for no or intermittent insurance for the uninsured and on/off groups, respectively.

TABLE 9

REASONS FOR BEING UNINSURED

	UNINSURED	ON/OFF
% Reporting reason was:		
Not offered through work	3.2	20.6
Too expensive	83.1	57.0
Didn't need/want insurance	7.2	6.3
Refused because of poor health	2.5	< 1
Lost job	< 1	30.6

AMERICAN ACADEMY OF ACTUARIES

November 26, 1991

Mr. Robert J. Leonard
Chief Counsel
Committee on Ways & Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Leonard:

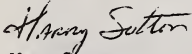
On behalf of the American Academy of Actuaries' Committee on Health, I am submitting the attached statement for the record of the Subcommittee on Health's May 2, 1991 hearing, "Health Insurance Options: Reform of Private Health Insurance." This statement is in response to a question raised by Subcommittee Members during the testimony of the Academy's Committee on Health.

Specifically, the statement addresses the issue of the effect of community rating on premiums for small employer groups. Unlike other such statements of which the Academy's committee is aware, the enclosed statement includes analysis of existing insurance data to arrive at its conclusions.

As you know, the American Academy of Actuaries does not advocate public policy positions which are not actuarial in nature. The Academy views its role as providing information and actuarial analysis to policy makers so that decisions can be made with informed judgment. We hope the analysis of the enclosed statement is consistent with our objective.

The Academy's Committee on Health prepared the enclosed statement. The committee would be most willing to assist the Subcommittee on Health and its staff in any way that the Subcommittee might deem appropriate. The contact persons for the Academy's committee are Gary Hendricks or David Bryant. Either may be reached via mail at 1720 I Street, N.W., 7th Floor, Washington, DC 20006 or by telephone at (202) 223-8196.

Sincerely,



Harry Sutton
Vice Chairman
Committee on Health

AMERICAN ACADEMY OF ACTUARIES

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
HEARINGS ON
HEALTH INSURANCE OPTIONS: REFORM OF PRIVATE HEALTH INSURANCE

ADDITIONAL COMMENTS
BY THE
COMMITTEE ON HEALTH
AMERICAN ACADEMY OF ACTUARIES

SEPTEMBER 9, 1991

THE EFFECT OF COMMUNITY RATING ON PREMIUMS FOR SMALL GROUPS

Introduction

On May 2, 1991 the Committee on Health of the American Academy of Actuaries testified before the Subcommittee on issues related to reforming health insurance for small employer groups. At that hearing members of the subcommittee posed the question:

What would happen to individuals who are currently insured in small groups if the law were to require the use of community rates?

In the opinion of the Academy's committee, the answer to this question is of fundamental importance to the Subcommittee on Health's deliberations on small group health insurance reform.

In the discussion that follows the committee has outlined briefly current underwriting practices, restated what the committee believes are the concerns of Congress, and presented data that indicate the magnitude of changes in rates individuals and groups would confront if community rating were to replace current underwriting practices in the small group market.

Representatives of the Academy Committee on Health would welcome the opportunity to discuss the data in Exhibits 1 and 2, as well as other issues related to community rating, with members of the subcommittee and their staff.

Current Operation of the Small Group Market

A number of insurance carriers use premium rates that do not differ widely from one insured small group to another, and a few insurers in a few locations even use community rates. This is particularly true for some Blue Cross/Blue Shield plans and for some HMOs. However, the practice of community rating, or nearly community rating, is clearly the exception and is becoming increasingly rare.

Most of the small group market is characterized by careful underwriting, the widespread use of policies with pre-existing conditions exclusions, and premium rates which vary by demographics, industry or occupation, and geographic location. In addition, particular policies may include benefit limitations and exclusionary riders to limit the liability for high risk individuals in the group or for certain health conditions. Some insurers charge much higher rates for a group that includes a substandard risk, and some practice outright rejection for certain industries and for high risk small groups.

Rerating systems are also used extensively in the small group market. Although there are mild forms of durational rating, there are also forms of tier rerating that result in a relatively small number of groups receiving very large rate increases if the group has poor claims experience or evidence of pending catastrophic claims is discovered in a review of the employer's account.

Finally, the small group market is characterized by frequent changes in insurance carrier. Because of the high and ever-increasing cost of health insurance, small employers conduct a never-ending search for the lowest possible rate. There is continual movement of the healthier groups to new carriers who will offer a low rate if the group can pass the underwriting screens.

Congressional Concerns and Community Rating as a Proposed Solution

Many Members of Congress have expressed concern with the wide rate variation among small groups, with widespread limitations on the coverage of pre-existing conditions, and with the instability of coverage that results from various durational rating schemes used by insurers. Some have suggested that a partial solution would be to mandate community rating for small groups. The proponents of such changes believe that community rating would be a fairer system and would lead to much more affordable access to insurance for many small groups who currently find it unaffordable. Others would go further. They would ban limitations on the coverage of pre-existing conditions and require insurers to issue a policy to any small group that applied.

To date, Congress has received little actual data that demonstrate the effect of such changes on those who are currently insured in small groups and on the affordability of small group insurance to currently uninsured small groups.

In the sections that follow, the Academy Committee on Health presents data that give some indication of the magnitude of the changes in prices that might be expected.

Impact of Community Rating on Currently Insured Small Groups

If legislation were to require shifting the existing market to a community rate, what would the resulting pattern of rate changes be for those already insured? Data that shed some light on this question are contained in Exhibit 1.

The data in Exhibit 1 were obtained with the permission of the Insurance General Management Consulting Division of Towers Perrin and Blue Cross and Blue Shield of Massachusetts. By way of background, Blue Cross and Blue Shield has a pool for small groups which have historically not been underwritten. Blue Cross and Blue Shield has acted as an insurer of last resort. The Towers Perrin study was related to planning revisions in their system of offering coverage to small groups and individuals to improve the Blue Cross and Blue Shield position in the Massachusetts marketplace.

The small group data used to construct Exhibit 1 were derived from the actual inforce insurance of a commercial carrier. In the analysis the enrollees in the carrier's small groups were first broken down by rate level. The change in rate was then calculated for each individual enrollee when a community rate was applied to all of the carrier's small groups. Finally, the percentage change in each enrollee's rate was calculated. The results of this final calculation are tabulated in Exhibit 1.

The exhibit shows that, if the small groups were community rated, approximately 63% of enrollees would have rate increases ranging from below 5% to over 40%. At the other end of the scale, 37% of enrollees would have rate decreases ranging from near 5% to over 30%.

Of particular note in Exhibit 1 is the large number of enrollees who would have rate decreases in excess of 30% (13.4% of the enrollment). This is a normal expectation where the insurance carrier has implemented substantial rate increases for a number of small groups with catastrophic and continuing high claims. Thus, there are possibly 10% or more of the total enrollees in this small group population who may have premiums 50% or more above the average because they are in a high-cost small group. When moving to a community rate, financing the health insurance claims of the high cost groups requires that nearly two-thirds of the enrollees receive rate increases, and 25% of those getting rate increases will have increases in excess of 30%.

The reader should note that the data in Exhibit 1 may understate the percent of enrollees who would experience rate increases and the amount of those increases. The analysis did not include the effect of the typical first-year discount for a group that is newly underwritten. Thus, the spread of changes in rates might be somewhat wider than the exhibit indicates.

Impact of Community Rating on Average Premium Costs

The previous paragraphs discuss the affect of rate increases between small employers and their employees if community rating were applied only to small groups that currently have health insurance coverage. What additionally would happen if guaranteed issue were required, limitations on pre-existing conditions were not permitted, and community rates were applied to nearly universal coverage of small groups and individuals?

Exhibit 2 is an analysis of the effect of requiring a community rating system for existing individual insurance, existing group insurance for employers with fewer than 30 employees, and the uninsured picked up through a proposed Minnesota universal coverage plan. The groups to be included in the proposed Minnesota plan are the uninsured, those with existing individual

insurance coverage, those covered under MCHA (the state pool for uninsurables), those covered by Minnesota's Children's Health Plan (CHP), and those covered under existing small group plans. All members of all groups would be required to participate in the new state program.

Under the proposed Minnesota program, approximately 1.5 million people would be covered. Of these, 80% are already covered by private health insurance either through individual policies or small group plans (column 2 of Exhibit 2). Eighteen percent of the program's expected enrollees are currently uninsured.

The analysis shows that, when a community rate that covers all expected costs is applied to the entire group (including the uninsured), the average rate paid by those with individual insurance must increase by 11%. The average rate for currently insured small groups must be increased by 10%. These higher rates are required to subsidize those who are currently uninsured and the uninsurables in the state's MCHA program. Under a community rating system, the rate paid for the uninsured will not cover their expected insured health care expenditures. In fact, as shown in the last column of Exhibit 2, the community rated premiums paid for the currently uninsured will fall 21% short of their expected expenditures. Thus, they will require a +21% subsidy from other groups in the community-rated pool.

The magnitude of the cross-subsidies shown in Exhibit 2 depends upon the differences in expected per capita health expenditures among the groups in the community-rated pool. In Exhibit 2 these differences are measured by the health status ratio. The higher the ratio the greater the expected health care expenditures. If there were no differences in the health status ratios in Exhibit 2, there would be no subsidization across groups.

There are a number of reasons to expect the differences in health care expenditures indicated in Exhibit 2. Those covered under individual and small group health insurance have already been underwritten and, hence, are somewhat better than average health risks. Members of the uninsured group, on the other hand, either have not been underwritten or already have been rejected for health insurance. Moreover, the currently uninsured group includes a disproportionate share of lower-income individuals. The firm that conducted the analysis underlying Exhibit 2 based its assessment of the expected health care expenditures of the uninsured in part on the experience of the AFDC population, which is also low income.

It's important to point out that the 10% to 11% increase in rates for those currently insured is only meaningful if all people are covered under a universal health program. If the uninsured have access to health coverage on a voluntary basis, then self-selection at the time of enrollment will increase the number of poor risks covered. Those who are young or in good health will tend not to enroll, while those who are older or in poorer health will enroll. This would lead to greater — perhaps significantly greater — increases in the average community rate, and greater increases in the rates for those already insured than the 10% to 11% is suggested in the analysis for Minnesota.

Conclusion

If we superimpose a 10% rate increase on top of the matrix of rate changes shown in Exhibit 1, approximately 75% of all individuals and small employers who have to purchase health coverage would have rate increases ranging from 5% to in excess of 50%. Those getting the biggest rate increases would be young males. The biggest decreases would be for individuals over age 50 and those seriously impaired with lifethreatening conditions.

If the system is mandatory and everyone must become covered, a community rate, or something closer to it, may be feasible if coupled with government action to raise the money to pay for premiums for low-income individuals. In a voluntary market, with sizable increases in rates for the lowest-cost insured population, there will be a tremendous incentive for the youngest groups and the groups in the best health to terminate their insurance or become self insured. This would produce a rapidly increasing cost trend for those who remain insured who, although they may have access, will find it increasingly burdensome to pay.

As indicated in previous testimony (Hearings of the Ways and Means Subcommittee on Health, May 2, 1991), the Academy committee believes that it will require a long transition period to compress the current highly diverse rates toward community rates. This must be done slowly so as not to disrupt the current insurance market and rapidly decrease coverage through sudden, sharp increases in premiums for many currently insured groups.

The committee would also like to emphasize that community rating will not lower the average cost of insurance. Thus, community rating is not a solution to covering lower-income people. This group will require major financial subsidies for health insurance. To the extent that small group reform proposals do not create funding to purchase coverage for lower-income people, such proposals, which generally will raise premiums, will thwart the objective of decreasing the number of uninsured.

EXHIBIT 1

The Effect on Enrollees' Premiums of Converting a Small Group Line of Business to Community Rates

<u>Percentage Change in the Premium Rate</u>	<u>Percent of Enrollees Effectuated</u>
+40% or more	10.3
+30% to +40%	14.6
+20% to +30%	13.0
+10% to +20%	8.3
+5% to +10%	6.0
0% to +5%	9.9
0% to -5%	10.6
-5% to -10%	7.1
-10% to -20%	5.7
-20% to -30%	1.1
-30% or more	<u>13.4</u>
Total	100.0%

NOTES:

- (1) Towers Perrin, Insurance General Management Consulting, developed these data in the context of research for Blue Cross/Blue Shield of Massachusetts.
- (2) The commercial carrier from whose business these data were derived uses aggressive underwriting, rates groups by age and industry, and uses tier rating.
- (3) The impact of first year discounts for newly underwritten groups is not included in this analysis. Thus, the data may somewhat understate the percentage changes in premium rates.

EXHIBIT 2

Estimated Cross-Subsidies from Imposing a Community-Rated State Program on Groups with Different Initial Insured Statuses

<u>Pre-Program Health Insurance Status</u>	<u>Enrollment (in 1000s)</u>	<u>Percent of Enrollees</u>	<u>Health Status Ratio</u>	<u>Subsidy</u>
Uninsured	259	17.8	1.48	+21%
Individual Insurance	352	24.2	1.06	-11%
MCHA State Program	17	1.2	3.68	+68%
CHP State Program	13	.9	1.15	-2%
Small Group Insurance	<u>814</u>	<u>55.9</u>	<u>1.07</u>	<u>-10%</u>
Total	1455	100.0%	1.17	0%

NOTES:

- (1) The data were developed from Program Cost Estimates for the Minnesota Health Care Access Commission, a December 6, 1990 report by Milliman & Robertson, Inc.
- (2) The "Health Status Ratio" is the expected health insurance claims for the group relative to claims of large employer groups. Thus, the uninsured in Minnesota are expected to have health care costs that are 48% higher, on average, than the average cost for large employer groups. The assumed higher cost for the uninsured in Minnesota was based in part on the experience of the AFDC population.
- (3) The subsidy for each group is the percent by which the group's expected costs will be above or below the community rate. The pre-program uninsured group was estimated to cost 21% more than the premiums paid on their behalf. The insured health expenditures of those previously covered by individual private insurance policies will cost 11% less than the community-rated premiums that they would pay under the proposed state program. The MCHA population requires such high subsidization (+68%) because MCHA is an existing program that covers an uninsurable population in Minnesota.

Mr. Russo. Thank you very much, Mr. Sutton.

The gentlelady from Connecticut, Mrs. Johnson.

Mrs. JOHNSON. Thank you very much.

I want to bring us back to this issue of community rating. Mr. Nadel, I heard you say that community rating declined as costs increased, and the effort to relate risk to premium was a direct consequence of the need to find some lower cost alternatives. Is that correct?

Mr. NADEL. Well, the dynamic was that everyone is willing to pay the same premium as long as premiums were generally low. At one time we didn't talk about a health care cost crisis, although it wasn't that long ago. It was within our recent memory.

As those costs went up, insurers and companies realized—at least those companies that had younger work forces, particularly, realized that perhaps they could do better. And in a competitive market—this is a story almost without villains. Everyone was following their own self-interests, and that led us to quite a morass.

Following their economic self-interest, commercial insurers figured they could find companies that they could charge lower premiums to because they were better risks. So they pulled those companies out of the normal community-rated pool.

Well, what happens, of course, is that your average risk then increases. The folks who were left were the older, the sicker, and so on. So to cover those people, costs go up. So you start getting a—

Mrs. JOHNSON. It wasn't just that what was left were older and sicker. What was left were those who used the new testing methods, the new treatments, the new specialists and so on, who used the increasingly costly health care system more. So I think the first cause is the rising cost of health care, which then drove a competitive industry to look for a way to keep premiums down.

The reason I think this is important is the ethical issue of do we have a right to impose community rating now as a single answer without first controlling costs, narrowing mandates, or doing some of the things you suggest. What are the ethics of imposing community ratings when at one hearing we heard the testimony that 85 percent of those now paying premiums would pay higher premiums. I would be interested in what your estimate, those of you on the panel, is as to how many people's premiums would go up if we went to community rating as to going down, because we would not in the short term be able to couple it with any narrowing of focus of benefits.

Mr. NADEL. The ethical and public policy issues here are truly daunting. The curve on the use of health care shows that—and I forget the exact percentages, but a fairly small percent of the population uses most health care resources in this country. So unless you were just going to cast them on a liferaft, so to speak, on their own, there is going to be some cross-subsidization. This is something that GAO obviously can't prescribe. I think it is a kind of consideration that Congress has to make. To what extent are we all our brothers' and sisters' keepers? And what is the function—another more mundane issue is: What is insurance?

Mr. SUTTON. I would like to answer your question also about community rating. In the long term, I have no real objection to a community rating. But the system we have now uses demographic

rating, even HMO's, and to change overnight would completely disrupt the system. I really feel it will take a 5- to 10-year period in transition to narrow the rate spreads between different groups. I mean, the rate spread can be as much as 8-to-1, if you have a very young male group and then an older working group and so on. Changing it overnight would disrupt the system.

We studied Minnesota's proposal for universal health care, and in order to get the money to cover the uninsured, essentially out of 1.5 million with small groups or individuals or the uninsured, 80 percent of them would have all their premium rates raised 10 percent or more to cover this—to provide the State the subsidy to cover the uninsured, plus State money on top of it.

Mrs. JOHNSON. Could I ask you all to take a look at the sort of compromise that we developed in my bill? I am not an expert on this by any means, but caught between the implications of community rating and the implications of doing nothing, I have limited the amount of variation between blocks of business and within blocks of business. If you would give me your frank analysis of all of that in the context of what you said, I would appreciate that.

If I could just say one last thing, Mr. Chairman. Am I correct in understanding that if we went to community rating, we couldn't differentiate between smoker and nonsmoker rates? Is it that rigid a system?

Mr. SUTTON. It doesn't have to be. Community rating has a lot of different meanings to different people. Much of community rating, at least, looks at demographics of populations and geographic variations and other factors.

Mrs. JOHNSON. I think it would be important to have some individual habit capability. I just wanted to see what that definition was, and any comments you have on that in the future, I would appreciate. Thanks.

Thanks, Mr. Chairman, for your patience.

Mr. Russo. Let me just say, after sitting here listening to this testimony and how you respond to the questions on community rating and risks and redlining, it seems to me the simple thing is, if the survey was accurate—and I assume the survey of Mr. Hall was very accurate—about 70 percent of the small business people in this country believe it is a right to have health insurance, health care. It seems to me we can solve all these problems that you talk about by going to a universal plan where everyone is treated the same and it won't cost you any more money than you are paying today. It never ceases to amaze me how long it takes Americans to smarten up to do the right thing, but eventually they do over the long run.

Let me ask you this: How readily can insurers select only the best risks through their marketing practices?

Mr. SUTTON. In small groups, they can select extremely well. Health status for an individual is an extremely good indicator of likely expenditures, even though you can't guess them exactly. We discussed at a meeting yesterday that some carriers are doing health underwriting on groups as big as 50, and even up to 100 now, because it is such a big controller of estimating future health costs. In the first year of a small group, after you have underwritten the whole group, the cost could be 30 to 50 percent lower than

the ultimate cost after the selection wears off. So it is a very major factor, and insurers are well able to underwrite the health status of individuals if they have the opportunity.

Mr. Russo. I suspect it is true that as they gain experience with the group, then the premiums tend to rise more. Is that true?

Mr. SUTTON. Right. The selection factors and rejecting high-risk individuals, for example, probably wears off somewhere from 18 months to 2½ years.

Mr. Russo. Mr. Etheredge.

Mr. ETHEREDGE. I think it is important to recognize that the problems we are seeing today in the small group market in underwriting, as just pointed out, are rapidly moving into the mainstream of insurance practices. And I would hope that, as the committee begins to deal with the principles that should govern the small group market—like not putting in preexisting condition limitations for people who have been insured all their lives—that you will also apply those to help those in larger firms who are finding that their ability to change jobs and keep insurance is being impaired by these kinds of screening.

Unfortunately, the problem is most acute in the small group market. But the economics of experience rating that were laid out for you, the economics that 5 percent of the population accounts for 50 percent of the care, that is affecting employment screening for larger employers. Larger employers are being told that the easiest way to cut your health expenses is to screen out people before you hire them.

Mr. Russo. It seems to me that all we spend time doing is figuring out how to deny access to people. In a system that spends 12.5 percent of its GNP, or \$670 billion, we spend a tremendous amount of time trying to figure out how not to cover people. That is one reason why you have the problems you have in this country, and that is why the New York Times and the Washington Post and the journals now are carrying more and more articles about health care. This is an industry that spends its time just trying to make money, not necessarily covering people.

Do any of you know what the rate of return is for insurers that they earn on their health insurance business?

Mr. SUTTON. Most of them periodically lose money in their health insurance business. Right now they are at slightly an up cycle. Three years ago, the combined Blues, insurance carriers, and HMO's lost about \$7 billion in total. They are now up to where they are much more profitable. I think Blue Cross Association made a profit—made a profit of about \$2 billion last year. I am not sure how much insurance companies made. I don't think a lot. But it is a very cyclical business. Over the long term, I do not believe that it has been a very profitable business. Many insurance carriers are dropping out of the business, and a number of carriers, including the Blues, are at high risk.

Mr. Russo. Well, that is good news to me because the bottom line is when they complain to me that they don't like universal coverage, I see it as a way of saving them \$7 billion a year if I put them out of business.

Thank you very much.

Mr. Russo. Our last witnesses are a panel consisting of Blue Cross and Blue Shield Association, represented by Bernard Tresnowski; the Group Health Association of America, represented by James Walworth; the Health Insurance Association of America, represented by Rick Curtis. All your testimony will be made part of the record, and you may proceed, Mr. Tresnowski, to summarize your testimony.

STATEMENT OF BERNARD R. TRESNOWSKI, PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. TRESNOWSKI. Thank you very much, Mr. Chairman. Before I comment on our suggested reform for the small group market, I want to underscore and stress that the cost of health insurance is the primary reason small employers don't offer coverage to their employees. We believe that there is much the insurance industry can do to manage and restrain the increase in subscriber costs. However, small group market reform should not be viewed as a strategy to reduce costs for employers. It is, rather, a strategy to make sure that every small employer can purchase coverage for his employees that is fairly priced and that won't be discontinued because of high claims cost.

Earlier this year, our board of directors unanimously approved a position on reform of the small group market. Our first major principle is that all small groups should have access to private coverage regardless of their medical condition, location, or occupation. To achieve that objective, we believe that States should have available a range of options for assuring that private coverage is available.

The most frequently discussed approach would require all carriers in the State to accept all groups for coverage—guaranteed issue. Most insurers are adamant that in order to accept all groups, they would need a reinsurance mechanism to spread the costs of high-risk groups. While reinsurance may be appropriate in some States where participation in reinsurance is voluntary, we believe it is equally important for States to be able to choose approaches that achieve the objective of guaranteed availability without the use of reinsurance. Reinsurance has not been tested in any State. It may prove to be extremely complex, difficult to regulate, costly to administer, and unfair to some insurers.

One alternative that would assure that coverage is available to all small groups would be identifying at least one insurer that voluntarily provides such coverage and meets all other requirements.

This approach recognizes that in some States at least one insurer already offers comprehensive coverage on a guaranteed issue basis to small employers. For example, in New York and Pennsylvania, Blue Cross and Blue Shield plans in those States now offer year-round open enrollment for all their small group products and charge a single rate for all small groups in an area. Requiring other insurers in the State to guarantee issue coverage would be unnecessary under those circumstances.

Another approach would require all insurers in the small group market to accept otherwise uninsurable groups through placement of such groups by a State program. Uninsurable groups would select coverage from the carriers in the State under rules set up to

assure fair distribution of such groups. This alternative has the advantage of providing incentives for insurers to manage high-risk cases, being easier and less expensive to administer, and simpler to enforce than a reinsurance mechanism.

A second principle in our proposal for us is that small group coverage should be provided at fairly established rates. We support the rating reforms adopted by the NAIC in December. These reforms address the problem of carriers pricing small group coverage based on the risk of a specific group. Risk-based pricing without limits has resulted in very high rates for some small groups. We urge the Congress to rely on the NAIC model for any rating reforms. The NAIC has balanced carefully the need to reduce rates for high-risk, high-cost subscribers without increasing rates significantly for healthier subscribers. The NAIC rules will moderate the rates for high risk and stop some of the most egregious pricing practices in the small group market.

A third reform in our proposal we are supporting is to assure that no small employer is dropped from coverage because of poor claims experience. Another of our reform objectives is to address the problem of unregulated entities that provide small group coverage. That point was recently made by Mr. Sutton in his testimony. Unless these self-funded entities—for example, the so-called MEWA's—are brought under the direct regulation of the State, a very large part of the market will be free to continue their current enrollment and rating practices.

In conclusion, we share the committee's concerns about the cost and availability of insurance coverage for small employers, and we look forward to working with you to find a way to address these problems. Mr. Chairman, I stand ready to answer any questions you may have.

[The prepared statement follows:]

**STATEMENT OF BERNARD R. TRESNOWSKI, PRESIDENT,
BLUE CROSS AND BLUE SHIELD ASSOCIATION**

Mr. Chairman, and Members of the Committee, I am Bernard R. Tresnowski, President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 73 Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for more than 80 million Americans.

Today's hearing has been called to focus on reforms in the private insurance market. It is well understood that the overwhelming reason employers, especially small employers, do not provide health benefits is cost. However, as the debate has unfolded in the past few years, the focus has turned to insurer practices, particularly in the small group market.

Specific concerns in the small group market include the cost of coverage and the availability of reasonably priced insurance products for groups that have very high-risk, high-cost employees.

These concerns, coupled with the large number of people working for small employers who do not have health insurance coverage, have made reform of the small group market of critical concern to policy makers and the insurance industry alike.

In my testimony, I will comment on both of these concerns and on the small group insurance reform bill introduced by Representatives Johnson and Chandler, and then turn to the Blue Cross and Blue Shield System's response and recommendations.

Affordability

In addressing the larger issue of why many small employers find health insurance unaffordable, it is important to understand that there are many components of health care cost increases, including practice patterns of providers, consumer demand for health care services, new technology, demographic changes, costs associated with medical malpractice and excess capital.

Blue Cross and Blue Shield Plans, have a long history of working to control costs directly. Plans efforts include contract arrangements with hospitals that limit subscribers' liability while assuring that we pay only a reasonable amount for covered services. We also have contract arrangements with physicians that limit payments to amounts that are reasonable and protect subscribers from "balance billing." In addition, Plans have pursued, over the years, aggressive programs to control unnecessary utilization and avoid the provision of services that are not medically necessary.

Our focus on cost control has sharpened in recent years as overall health care costs have escalated. Our current cost control efforts include broad use of pre-authorization of health services, concurrent utilization review, post-payment review, discharge planning and individual case management. We also have improved our strategies for negotiating reimbursement rates and increasingly select providers in our managed care networks to achieve cost effective, quality care.

We believe that through these and other measures there is much the insurance industry can do to manage and restrain increases in subscribers' costs. However, it is important to understand that even with the most aggressive efforts to use only the most efficient providers and to manage subscribers' use of the health care system, the cost of health care will remain out of reach for many employers, and in particular, small, marginally profitable employers.

Insurer Practices

We believe reform of the small group market can do much to make fairly priced insurance coverage more available to all small employers. Our support of small group market reform recognizes that certain insurer practices have an affect on both the cost

and availability of coverage for small employers. As the market for small group health insurance has become more competitive, practices have emerged such as screening out or denying coverage to high-risk applicants and charging such applicants higher rates. In this competitive market, insurers that accept all risks, or have even marginally more liberal enrollment practices, will have higher-cost enrollees than their competitors. Consequently, they are forced to charge higher rates than insurers that have been more selective. These higher rates reflect the fact that only a few high-cost enrollees can generate substantial claims costs. On average, only 4% of insured individuals generate 50% of claims expenses, while 20% of enrollees generate 80% of claims.

As insurers with more liberal enrollment practices adjust their rates to reflect their higher costs, they lose their low-risk enrollees -- who can find better-priced coverage elsewhere -- and keep their higher-risk enrollees, who have nowhere else to go. These insurers thus are left with risk pools that gradually deteriorate over time.

This phenomenon is known as the "adverse selection spiral" and it explains why few insurers can continue to accept high-risk groups and still remain competitive. It also explains why more groups are found to be "uninsurable" or insurable only at high cost.

The competition for the lowest-risk enrollees also leads to pricing coverage at levels that more closely reflect the risk of a particular group or individual. The cumulative effect has been an increasing segmentation of the small group insurance market and a declining ability of Blue Cross and Blue Shield Plans to continue to retain their early practices of accepting all groups and community rating their coverage, while remaining competitive in this market. While a number of Plans continue to provide coverage on an open enrollment, community rated basis in the small group market, other Plans have had to change their practices in order to compete in this market.

The Blue Cross and Blue Shield Association believes that reforms are necessary to replace competition based on risk selection with competition based on administrative efficiency, service, and ability to control costs. In January of this year, the Board of Directors of the Blue Cross and Blue Shield Association unanimously approved a position on reform of insurance practices in the small groups market.

Specifically, the Blue Cross and Blue Shield System supports:

- o Assuring that small employers have access to private insurance, regardless of health status, occupation or geographic location;
- o Assuring that states have a range of options to choose from in providing for the availability of private insurance to small employers;
- o Assuring that small group coverage is provided at fairly established rates;
- o Assuring that no small employer is dropped from coverage because of poor claims experience;
- o Assuring the adequate, effective enforcement of all insurer requirements;
- o Assuring the equitable sharing among insurers of both high-risk small employers and the losses associated with covering these high risks; and
- o Assuring the availability of lower-cost products.

I'd like to discuss each of these initiatives in more detail.

Assuring Access. With respect to assuring small employers access to private insurance, the Blue Cross and Blue Shield Association believes that states should have the flexibility to choose an approach that meets the needs of their environments. One approach that has received considerable attention would require all insurers to offer coverage to small employers on a guaranteed issue basis, that is, without regard to health status or claims experience. For many insurers, this approach to assuring availability is dependent on a mechanism to spread the risk of accepting all groups -- a private reinsurance mechanism.

A key issue under this approach is whether all insurers would be required to participate in reinsurance or other risk-sharing programs. We strongly believe that participation in a reinsurance program should be voluntary. Under a voluntary approach, insurers willing and able to assume all costs associated with accepting all small employers within the set rating bands would not be required to participate in any risk-sharing program. The key characteristic of a voluntary approach is that carriers willing to opt out would accept the full risk of enrolling all small groups, rather than spread the risk, as under a reinsurance approach. These carriers would, however, have to meet all of the other carrier requirements. A mandatory approach, by contrast, would require participation by all insurers in the market, regardless of their current enrollment and rating practices.

Carriers willing to opt out of reinsurance could avoid the costs of medical underwriting that would be required to identify high-risk individuals or groups at enrollment for reinsurance under a prospective approach. They also could avoid the uncertain costs and complexities of a reinsurance program.

A voluntary approach also accommodates insurers that already accept all groups and, therefore, already manage and finance the care of high-risk groups and individuals. Under a mandatory reinsurance proposal, these insurers would have to start medical underwriting to send their "fair share" of risks to the reinsurance pool. Otherwise, such insurers would be paying twice -- once for the high risks they already were covering and once again to subsidize the high risks of other carriers through the reinsurance mechanism.

There are numerous other issues involved in the design of a reinsurance program. One such issue is the amount of risk that would be retained by individual insurers participating in a reinsurance program, as compared to the amount of risk that would be shared by all insurers. We believe that requiring individual insurers to assume more of the risk of uninsurable employers both encourages insurers to manage the use of health care services and reduces the volume of claims covered in the reinsurance program.

In states where reinsurance mechanisms are appropriate, we also support a program that is more akin to traditional reinsurance programs -- a retrospective reinsurance program. A retrospective program would identify and reinsure eligible groups only after they have incurred a significant amount of claims.

Because of the complexities and evolutionary state of reinsurance programs, we believe that most of the design issues should be left to the states. This flexibility would assure that the approach adopted would be appropriate for a particular state environment.

While a reinsurance approach may be appropriate in some states, we believe it is equally important for states to be able to choose approaches that do not rely on a reinsurance mechanism to spread the risk of a requirement that all carriers accept all groups. Reinsurance has not been tested in any state. It may prove difficult to regulate, costly to administer and

unfair to some insurers. In addition, the losses are unknown and could require additional funding.

The alternative programs that we recommend would assure that all small groups had access to private coverage and that all insurers met the general principals I just discussed.

These alternatives include those that:

- o Assure that coverage is available to all small groups through at least one insurer that voluntarily provides such coverage and meets all other requirements.

This approach recognizes that in some states an insurer (or insurers) already offer comprehensive coverage on a guaranteed issue, community rated basis to small employers. For example, in New York and Pennsylvania, Blue Cross and Blue Shield Plans offer year-round "open enrollment" for all their small group products and charge a single rate for all small groups in an area. They are able to offset the costs of these practices through a combination of negotiations with hospitals and physicians, a waiver from certain state taxes and aggressive cost containment activities. In these states, the goal of assuring access has been met, and the introduction of a complex and expensive new program is unnecessary. However, to moderate practices throughout the small group market, it may be appropriate to require all insurers to meet standards such as rating and renewal requirements.

- o Require all insurers in the small group market to accept otherwise uninsurable groups through placement of such groups by a state program. Under this approach, groups that have been found to be uninsurable by an insurer would register with a state program. They would be allowed to select coverage under rules set up to assure fair distribution of such groups among all small group carriers in the state.

This alternative has the advantages of providing incentives for insurers to manage high-risk cases, being easier and less expensive to administer and simpler to enforce than a reinsurance mechanism.

States also could develop other programs for assuring access to private coverage for small employers, as long as the alternatives achieved the objective of assuring access to all small employers at fairly established rates and met the other requirements described earlier.

Assuring Fairly Established Rates. The Blue Cross and Blue Shield Association also supports the rating reforms adopted by the National Association of Insurance Commissioners (NAIC) in December in the model act on Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups. These rating reforms address the problem of carriers' pricing small group coverage based on the risk of a specific group which can result in very high rates for some small groups.

The reforms would allow the use of demographic adjustments, that is, actuarial factors that predict health care utilization based on the characteristics of a group, but are not related to the specific claims experience or health status of a group. The reforms would limit the extent to which a group's own experience or health status could be used in setting its rates. In this way, an insurer's ability to set rates that more closely reflect a group's experience would be balanced with the need to subsidize the rates for higher-risk groups.

The reforms also would take the important step of limiting the amount of annual premium increases due to a group's own experience or health status. As a result of these reforms, rates for higher-risk groups would be moderated over time.

However, because the reforms would bring previously uninsurable groups into the insurance system and would redistribute the cost of higher-risk groups throughout the market, rates for lower-risk groups would increase.

It has been suggested that small group insurance reform include a requirement that all insurers offer coverage to small employers at a community rate. We believe such proposals are very problematic, for two key reasons.

First, we believe this approach would actually increase the number of uninsured groups. Uninsured groups tend to be comprised of younger and healthier employees who choose not to spend their wages on health insurance when they do not believe they will need it. If rates are "averaged out," the cost for higher-risk groups would decrease, but the rates for younger, healthier groups would increase. As a result more price sensitive groups may well drop their coverage. And the cost barriers that already exist for uninsured small groups will increase for many, making it even more difficult for them to purchase coverage.

And second, insurers that traditionally have had, or continue to have, more liberal enrollment practices can easily be placed at a major competitive disadvantage under a community rating requirement. As discussed earlier, their enrollment of higher-risk, higher-cost groups would result in an average rate that would not be competitive in the marketplace. And perversely, the requirement would reward insurers that have been very selective in the risks they accept.

Assuring Renewability of Coverage. We also support a prohibition against cancelling coverage of small groups because of poor claims experience. We believe insurers should be required to renew all coverage issued to small employers except for non-payment of premium, fraud or misrepresentation, noncompliance with plan provisions (such as a insurer's participation requirements), misuse of network provisions or if insurers cease to write new business in the small employer market. We believe that insurers that cease to write new business in this market should not be permitted to re-enter the market for five years.

Enforcement. Adequate enforcement is essential to the success of any of these approaches. Of particular importance is the inclusion of self-funded Multiple Employer Welfare Associations (MEWAs) and out-of-state trusts in any reform measures. In some states, these entities provide coverage to a substantial segment of the small group market. If they were not subject to market reforms along with other insurers, more and more of the insured small group market would be encouraged to move to these self-funded, unregulated entities, thereby, rendering any reform largely meaningless.

The Blue Cross and Blue Shield System also supports enforcement measures that would minimize insurer gaming. These measures could include a requirement that all entities selling small group coverage register with the state insurance commissioner and publish a list of these entities for distribution to small employers in the state.

Equity. We believe that any approach for assuring small employers access to private coverage should assure an equitable sharing among insurers in the small group market of the losses associated with covering high-risk small employers. We believe any reinsurance program should be designed to keep losses small enough to be financed within the small group market -- no more than five percent of small group premium. This is particularly important in light of the inequities that would arise if financing responsibility were extended to the large group market, because self-funded groups would not be required to participate in funding the potential losses because of the protections afforded them by ERISA. If financing beyond five percent of small employer premium were necessary, any

additional financing source must be as broad-based as possible.

Assuring Availability of Lower-Cost Products. Finally, in response to concerns about the high cost of small group coverage, we strongly support amending ERISA to exempt coverage sold to small employers from state-mandated coverage requirements. And we believe that insurers have a responsibility for developing lower-cost products for small employers.

Comments on H.R. 1565, "Health Equity and Access Reform Today Act of 1991"

Before concluding, I would like to comment briefly on the small group reform legislation recently introduced by representatives Nancy Johnson (R-CT) and Rod Chandler (R-WA).

We applaud Representatives Johnson and Chandler for taking a leadership role in the introduction of such comprehensive small group reform legislation. We support many of the provisions in the bill, including the rating and renewal requirements, the limitations on the use of waiting periods for pre-existing conditions and the continuity of coverage requirements. We also support the emphasis on managed care. The Blue Cross and Blue Shield Association feels strongly that any approach should encourage insurers to manage care -- particularly that of the high-risk cases that previously did not have access to private coverage.

We particularly support the bill's reliance on the states to enact legislation to implement the bill's requirements. In general, we support the approach of state adoption of NAIC models. However, states should retain their current flexibility to adapt NAIC models to meet the needs of their environments. This flexibility recognizes the evolutionary and untested nature of current proposals to assure small employers access to private insurance.

Our primary concern with the legislation is its use of only one approach -- guaranteed issue -- to assure access to private coverage for small employers. This approach leaves states no choice but to establish a reinsurance mechanism -- once again, an approach that is untested and may be difficult to regulate and costly to administer. As I discussed earlier, we believe states should have the flexibility to choose approaches that meet the needs of their environments, including approaches that do not require all carriers to guarantee issue coverage to small employers.

However, we strongly support the intention of the bill, which is to assure access to private coverage for all small employers and to take other measures to stabilize the small group insurance market.

Conclusion

In conclusion, the Blue Cross and Blue Shield Association shares the Committee's concerns about the cost and availability of insurance coverage for small employers, and we look forward to working with you to find a way to address these problems.

Mr. MOODY [presiding]. Thank you very much.
Mr. Walworth.

STATEMENT OF JAMES A. WALWORTH, PRESIDENT, HEALTH ALLIANCE PLAN OF MICHIGAN, AND CHAIRMAN OF THE BOARD, GROUP HEALTH ASSOCIATION OF AMERICA

Mr. WALWORTH. Thank you. Good morning. I am here this morning as chairman of the board of the Group Health Association of America, the Nation's oldest and largest HMO trade association. I am also president of the Health Alliance Plan of Michigan, a federally qualified health maintenance organization which serves over 400,000 members in the Detroit area.

HMO's provide quality, comprehensive health care services to their members in exchange for a predetermined, fixed monthly premium. Our emphasis is on prevention and early access to care to detect serious illness.

It is GHAA's view that, first, every American should have access to quality health care; second, Americans should have freedom to choose among a reasonable number of health plans, including HMO's; and, third, that HMO's should and can play an important role in any national health care proposal to deal with the uninsured.

In 1973, Congress passed the Federal HMO Act to encourage the growth of HMO's. A federally qualified HMO must meet standards that assure a comprehensive benefit package with limited cost sharing, that services are available and accessible, that the plan is fiscally sound, and that there is a quality assurance program in place.

Federally qualified HMO's are also restricted to using community rating, community rating by class, or more recently adjusted community rating in their premium setting.

While perhaps best known for their benefits as comprehensive, HMO's are also known for their cost containment features and their track record of holding down costs. We do this by establishing sound incentive arrangements with providers which are designed to promote efficient delivery of appropriate health care services, prospective budgeting, integrated delivery systems, preventive care services, and a focus on care in the ambulatory setting. Through their organizational efficiencies, HMO's are able to achieve continued cost savings over the long run, not just one-time cost savings as sometimes are reported in other managed care programs.

Despite the fiscal pressures to increase cost sharing and reduce benefits, the data on HMO benefit packages on the whole continue to show comprehensive programs, even for those HMO's that are not federally qualified.

GHAA members, when asked about the uninsured and reform of the small group market, are most concerned about creating a level playing field for themselves, providers, and insurers; the ability to provide affordable products given the standards that are imposed by Federal and State requirements, and, third, the potential that exists for adverse selection.

Given all this, there are certain elements unique to the method of HMO operations that warrant special consideration.

Managed care is one. There has been much discussion and confusion about this term. For almost 50 years the term managed care has been synonymous with HMO's and their predecessors. The rapid growth of HMO's over the last 10 years has had a permanent effect on America.

GHAA believes that managed care delivered through an HMO is unique in that it accomplished through establishing risk-sharing arrangements with providers and restructuring incentives away from fee for service. GHAA strongly believes that any true reform must include managed care and should clearly define and explain what is meant by that term, just as the HMO Act in 1973 defined the term HMO. We realize that is not an easy task, but neither was defining an HMO.

HMO's are especially concerned about State-mandated benefits because we already offer comprehensive benefits. GHAA believes that HMO's should be able to offer health benefit programs consistent with their basic methods of operation, and new requirements should avoid a conflict with the limited package of benefits that would cause conflict with the HMO Act.

Further, there are State laws increasingly present that prohibit exclusive or closed-panel provider arrangements that mandate contracts with classes of providers, require willing providers to be contracted with. These are in direct conflict with the essentially closed system of an HMO and obviously impede the HMO's ability to effectively manage care.

The practice of excluding coverage for preexisting conditions creates financial barriers to consumers and creates marketplace inequities for carriers like federally qualified HMO's that do not engage in this practice.

Any proposal that attempts to reform the small group market must address affordability. Community rating or rating under narrow rate bands would make coverage more affordable to high-risk small groups and still not penalize the most efficient carriers.

GHAA believes that any small group reinsurance program should be voluntary, with carriers permitted periodically to elect whether to participate. Additionally, reinsurance programs must be designed to reflect differences between HMO's that participate and other forms of carriers.

In the event of losses by the pool, an adjusted assessment would also be requested that reflect the cost-effectiveness of HMO's, the HMO Act limitation on the amount of risk which an HMO can re-insure, and the use of community rating.

Because HMO's oftentimes actually provide the care, they must also have adequate staff, facilities, and administrative capability to serve the members, and any new requirements that guarantee enrollment must take into account the HMO's capacity factor.

We believe the HMO industry serves as an example that quality, comprehensive health care services can be provided for an affordable price and that truly managed care has a role to play. We look forward to working with you and all the members of the subcommittee as you look through these issues.

Thank you.

[The prepared statement follows:]

**STATEMENT OF JIM WALWORTH, PRESIDENT,
HEALTH ALLIANCE PLAN OF MICHIGAN,
ON BEHALF OF GROUP HEALTH ASSOCIATION OF AMERICA, INC.**

Good morning Mr. Chairman and members of the Subcommittee. My name is Jim Walworth and I am Chairman of the Board for the Group Health Association of America (GHAA). GHAA is the nation's oldest and largest trade association representing HMOs. GHAA members account for 75 percent of the people enrolled nationwide in 569 HMOs.

I am also President of the Health Alliance Plan of Michigan, a federally qualified health maintenance organization (HMO) based in Detroit, Michigan. We are a non-profit staff, group and network HMO, serving over 400,000 members, including those enrolled under our Medicare risk, Medicaid, and Federal Employees Health Benefits Program contracts.

I have been asked to discuss some of the industry trends among HMOs, including federally qualified HMOs, and talk about HMO involvement in the small group market. I would also like to raise some issues that should be considered in any small group reform proposal to assure the equitable treatment of HMOs.

HMOs provide cost effective, quality, comprehensive health care services to members in exchange for a predetermined, fixed monthly premium. The emphasis is on early access to care in order to keep people healthy and to detect serious illness as early as possible.

It is GHAA's view that:

- o every American should have access to quality health care;
- o every American should have the freedom to choose among a reasonable number of health plans, including HMOs; and,
- o HMOs should play an important role in any national health care proposal that addresses the uninsured.

Since their development, HMOs have emerged to provide organized, prepaid, quality health care to over 36.5 million Americans nationwide. In many areas of the country, HMOs have a significant share of the market. For example, in the San Francisco Bay-Sacramento area, 46 percent of the population is enrolled in an HMO. Similarly, HMOs in the Minneapolis-St. Paul area have 44 percent of the market. In total, 22 percent of the population in the 30 largest U.S. metropolitan areas were enrolled in an HMO in 1989.

FEDERALLY QUALIFIED HMOs

In 1973, Congress passed the Federal HMO Act to encourage the growth of HMOs. This Act set forth standards for HMOs wishing to be "federally qualified." A federally qualified HMO must meet specific standards that assure the HMO provides a comprehensive benefit package with limited cost-sharing, that services are available and accessible, that the plan is fiscally sound, and importantly, that there is a quality assurance system in place.

Specifically, federally qualified HMOs are required to provide a number of basic benefits, these include: inpatient and outpatient physician and hospital services, emergency services, diagnostic laboratory and therapeutic services, preventive health services, short-term rehabilitation and physical therapy services, outpatient mental health services, and substance abuse services.

Copayments are restricted and deductibles for basic benefits are prohibited except for a limited point of service option permitted in 1988. Further, federally qualified HMOs are not permitted to have waiting periods or pre-existing condition exclusions for their group accounts.

By year end 1990, about half of all the HMOs in the country were federally qualified. However, enrollment in these HMOs represented 74 percent of total HMO enrollment.

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Now let me highlight some of the HMO industry trends as they relate to rating.

Rating Trends. Prior to 1988, HMOs which were federally qualified were only permitted to use two types of rating methods -- standard community rating (CR) and community rating by class (CRC). The HMO Act Amendments of 1988 added a new type of rating, adjusted community rating (ACR). ACR, while still a prospective rate, allows some adjustment in rates for anticipated group-specific experience. HMOs need the flexibility of ACR to respond to employer demands and remain competitive in the changing marketplace.

Briefly, CR, the "traditional" method of rating used by HMOs, involves setting prospective rates for all enrollees in a particular class of business, such as group or non-group. Within that class there are separate rates for "single" and "family" coverage.

CRC involves adjusting the community rate based on certain demographic characteristics of the group, such as age and sex. This allows younger, healthier groups within the class to get better rates since they are expected to have lower utilization. In turn, high risk groups will pay more.

ACR is a prospectively determined rate based on the expected experience of a particular group in a class of business. No retrospective adjustment is permitted, as true experience rating allows. To assure that federally qualified HMOs using ACR would still offer premiums affordable to small groups, the 1988 amendments limited the use of ACR for individuals and families in groups of 100 persons or less to 110 percent of the community rate.

Despite the use of ACR, HMO rating methods continue to differ considerably from those commonly used in writing indemnity insurance. Almost all rating within the HMO industry continues to be prospectively based. According to the GHAA Annual HMO Industry Survey, less than 10 percent of all established HMOs (those three years old and older) used any retrospective adjustment in setting rates in 1990. Most HMOs - 69 percent - used only community rating methods permissible under the HMO Act (This statistic includes federally qualified and nonfederally qualified plans.).

In 1990, 44 percent of HMOs used only CR or CRC in rate setting but GHAA data show that an increasing number of HMOs are making some explicit adjustment for group experience in setting rates. We expect to see a greater use of ACR in the future in the large group market. Since 1989 was the first full year that ACR was available as a rating method for federally qualified HMOs; many are still developing the data systems necessary to use this method of rating.

Benefits. HMO benefit packages reflect HMO commitment to access to comprehensive coverage that encourages preventive care and early treatment through low copayments. Despite fiscal pressures to increase cost sharing and reduce benefits, the GHAA data show that HMO benefit packages, on the whole, continue to be comprehensive even for those HMOs that are not federally qualified. For example:

- o 77 percent of established plans covered hospitalization without patient payment in 1990; virtually all (99 percent) covered primary care with no limit on the number of visits.
- o 72 percent of plans required a payment for primary care visits, almost always in the form of a fixed dollar copayment. The most common copayment was \$5. Generally, no extra charges were required for laboratory or radiology services.
- o While over 99 percent of plans covered prenatal and well baby care, only 50 percent and 57 percent respectively charged copayments for these services.
- o Also, 96 percent of HMOs covered prescription drugs in their best selling package. Although 90 percent offered this benefit with some patient cost sharing, the typical copayment was \$3-\$5 per prescription. Further, only 9 percent applied a dollar limit to this benefit.

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While 31 percent of HMOs altered benefits in their best selling package in 1989, this was usually done through cost sharing increases rather than elimination of, or limitations on benefits. However, limits on copayments and deductibles under the HMO Act affect a federally qualified HMO's ability to increase cost sharing in this area. This means that premiums are more likely to increase.

Premiums. As you know by now, availability of health coverage is only one part of the problem plaguing the American health care system. Affordability is another.

HMOs have a track record on holding down costs -- for government, private employers, and individual and family HMO members. Between 1987 and 1990, premium increases for HMOs -- group, staff and IPA models, were below that of traditional indemnity products, including those with cost containment features. HMOs do this in a number of ways.

HMOs provide care for patients for a preset fixed payment and have developed appropriate incentive arrangements with providers designed to promote efficient delivery of health care services.

This means that it is important to have monitoring systems to assure the quality of care is not jeopardized. All HMOs are required by law to have internal quality assurance systems to measure the quality and outcomes of care being delivered through the HMO. HMOs are also subject to external review of their quality. For example, those HMOs which contract with HCFA to provide Medicare services are subject to peer review organization (PRO) review of both ambulatory and hospital care. This type of oversight of HMO quality has no counterpart in the fee-for-service sector.

HMOs in Michigan are also participating in a unique quality review project involving the three automobile companies, the United Auto Workers and the National Committee for Quality Assurance (NCQA). During the next several years, NCQA will conduct a comprehensive review of each HMO using a four part approach that consists of an enrollee satisfaction survey, a review of the HMO's internal quality improvement system by a team of experts, focused review of medical records using explicit criteria, and assessment of access and quality of mental health and substance abuse services.

The goal of each HMO is to preserve quality care and eliminate unnecessary services. In this way, HMOs are able to achieve continued cost savings over the long run, not just one time cost-savings as reported in some other "managed care" systems.

Despite this approach, HMOs are still subject to cost increases due to outside factors such as: general medical inflation, hospital cost increases, physician contracts/salaries, state mandated benefits, pharmaceutical expenses, and growth in technology; and have therefore increased their premiums and cost sharing.

However, most HMOs felt that despite their premium increases in 1990, their appeal and market position remained favorable due to their rate advantage over fee-for-service products, their plan reputation and member satisfaction, the availability of new products to respond to employer demands for flexibility and better cost control and management.

HMO Small Group Market Trends

As discussion on access to health care has evolved, particular attention has been paid to the small employer market. Let me take a moment to talk about HMO involvement in this market.

According to the GHAA annual survey, 82 percent of established HMOs were involved in the small employer market (less than 25 employees) in 1990. HMOs varied in the minimum size employer group they would enroll. However, over half set a minimum size of five or fewer according to GHAA's HMO Market Position Report.

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Because small employer markets vary from place to place and industry to industry, so does their enrollment in HMOs. As a result, in areas where there is a high concentration of small group employers, some HMOs have more small employer group contract and have felt the need to develop products that better fit the needs of the small group market.

While some HMOs initially found, that on average, the utilization of health care services of small groups did not differ from large groups, there is reason to believe this may be changing due to changing market practices. Insurer practices such as not offering coverage to small groups, using strict medical underwriting and pre-existing condition exclusions make it considerably more likely that HMOs which don't use these practices, will suffer adverse selection associated with those people who cannot get affordable coverage elsewhere. This issue affects the ability of HMOs to provide coverage both to small groups as well as other enrollees.

In recent years HMOs have been involved in special initiatives targeting the uninsured. These include: developing specific products for small employers and individuals, demonstration projects with uninsured and needy populations, and dues subsidy programs. The GHAA 1990 HMO Market Position Report found that 61 percent of HMOs surveyed addressed the growing concern over the uninsured in 1990, or intended to in 1991, via new programs and changes within their plans.

Our members, when asked about reform of the small group market, are most concerned about creating a level playing field for all providers/insurers; the potential for adverse selection; and their ability to develop affordable products given standards imposed by the federal qualification requirements and by state mandates which require certain benefits and use of providers.

HMO SPECIFIC CONCERNS

GHAA is currently in the process of finalizing a position paper that details issues that must be considered to assure the equitable treatment of HMOs under any small group market reform proposal being considered.

Although GHAA is still in the process of developing its formal position statement, I would like to raise certain elements unique to the method of operation of HMOs that warrant special consideration under small group reform proposals. These include:

Capacity. The level of risk that HMOs accept is different than that of other carriers. In exchange for a set premium, HMOs are at risk for actually providing care needed by enrollees. Because the HMO actually provides the care, they also have a unique feature which affects their ability to enroll members - capacity.

The HMO must have adequate staff, facilities and administrative capability to serve its members. If enrollee growth substantially exceeds plan projections, an HMO may have to "freeze" or close enrollment to deal with such capacity considerations to assure that members have continued access to quality care. Any new requirements to "guarantee enrollment" must take into account the HMO's capacity factor.

In addition, an HMO should not be required to enroll a small group whose employees are located outside its service area, or provide coverage where acceptance of small group applications will impair the financial condition of the HMO.

Mandated Benefits/Providers. There has been much discussion about the impact of state mandated benefits. HMOs are specifically concerned about mandated benefits because HMOs already offer comprehensive benefits. GHAA strongly believes that HMOs should be permitted to continue to offer health benefits consistent with their basic method of operation. We are specifically concerned that any

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proposal which would require a carrier to offer a limited package of benefits may conflict with an HMO's basic method of operation and with the federal HMO Act.

In addition, state laws prohibiting exclusive or "closed-panel" provider arrangements, mandating contracts with classes of providers or mandating contracts with any willing provider, such as pharmacies, come into direct conflict with HMO operations. HMOs are essentially closed systems using restricted providers. They negotiate provider agreements with the most efficient, quality providers. Requiring HMOs to do business with all providers obviously impedes the HMO's ability to effectively manage care. GHAA strongly opposes impediments of this type.

Further, numerous and varied state mandates add to the cost of the benefit package, making them unaffordable to many. Mandating additional benefits, as many states have done, has a significant cost impact and detracts from the HMO's ability to offer the benefits desired by employer groups. HMOs are increasingly tailoring benefit packages to the needs of different employer groups - especially small employer groups, that are more price sensitive.

Reinsurance Program. HMOs accept risk differently from indemnity carriers. Because of this, GHAA believes that small group carriers in a guaranteed issue market should not be required to participate in a reinsurance pool or to finance pool losses. A small group reinsurance program should be voluntary, with carriers permitted periodically to elect whether to participate. A reinsurance program should be designed to limit assessments against carriers and to promote simplicity of administration.

In addition, reinsurance programs must be designed to reflect differences between HMOs that elect to participate in the reinsurance program and other participating carriers through a reduced reinsurance premium; and, in the event of losses by the pool, an adjusted assessment to reflect:

- 1) the efficiency of HMOs in managing risk,
- 2) the HMO Act limitation on the amount of risk for which an HMO can reinsure, and
- 3) the use of community rating - if assessments are to be calculated as a percentage of premium.

In order to limit the size of assessments and to promote cost effective management of care by all carriers, it is important that any reinsurance program should also include significant cost sharing by the carrier -- this will give the carrier incentive to be cost effective even after the reinsurance has kicked in.

Finally, we are concerned that any additional losses by the pool be covered through a broad based source. It would be inappropriate to extend second tier assessments to carriers who have elected not to participate in the reinsurance program and are assuming the full risk of their small group coverage.

Pre-existing Conditions Exclusion. The practice of excluding coverage for pre-existing conditions creates financial barriers to consumers with health problems and creates market place inequities for carriers like federally qualified HMOs that do not engage in this practice.

Pricing Limits. GHAA is concerned that any proposal that attempts to reform the small group market must address affordability. Proposals that allow wide rate variation between classes and industries do little to change the practices and problems faced by small group employers today. Community rating or rating under narrow rate bands would make coverage affordable to higher risk small groups and still not penalize the most efficient carriers.

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Size of the Group. Finally, GHAA is concerned about proposals that would require carriers in the small group market to enroll groups as small as one person. Establishing a minimum group size may be important where issuance of coverage is guaranteed to assure validity of the group and to minimize adverse selection for federally qualified HMOs, especially if other carriers are authorized to exclude coverage for pre-existing conditions.

Managed Care. Finally, regarding: "managed care". There has been much discussion -- and confusion -- about this term. It seems that today everyone in the health care market has a "managed care" or "case-managed" product.

For almost 50 years, the term managed care was synonymous with HMOs. This was because HMOs have always advocated an approach to health care which emphasizes cost efficient organized private sector systems which provide comprehensive quality health care.

The rapid growth of HMOs over the last ten years has had a permanent effect on health care in America. Just one example, is that HMOs have become a basis for a variety of initiatives and experiments which are now commonly labelled "managed care".

However, there is a difference between the managed care that HMOs provide and the many managed care products now on the market. GHAA believes that the managed care delivered through HMOs is unique in that it is accomplished through establishing risk sharing arrangements with providers, restructuring incentives away from fee-for-service care to prepayment, and integrating the elements of health care -- physicians, hospitals, -- into a coherent whole. Prevention and early detection are stressed to encourage physicians and others to keep their patients well and to intervene early in the disease process.

GHAA strongly suggests that any true health care reform must include managed care and should clearly define and explain what is meant by the term, just as the HMO Act of 1973 defined the term HMO. We realize this is no easy task, just as the HMO Act was no easy task, but we feel that to be deemed as managed care one should be required to meet certain acceptable standards.

CONCLUSION

GHAA believes the HMO industry serves as an example that quality, comprehensive health care services can be provided for an affordable price. In fact, many in the health care marketplace have copied HMO techniques in their "managed care" products in order to be more cost effective. The HMO model serves as an example with its rating methods and treatment of pre-existing conditions. However, the HMO's ability to continue to operate in this manner is affected by each local competitive market in which the HMO operates.

When Congress enacted the dual choice provision in the 1973 HMO Act, Congress gave employers and their employees the right to have comprehensive prepaid health care. Now, because of the changing market, more and more HMOs are finding it difficult to operate as they have in the past and yet remain competitive in the market.

GHAA strongly believes that managed care has a role to play in any plan to address the needs of the uninsured. We do, however, have certain characteristics that warrant special consideration -- the different level of risk accepted, capacity concerns and the impact of state anti-managed care legislation.

We look forward to working with you Mr. Chairman and members of the Subcommittee as you continue to discuss these issues and try and arrive at an effective and equitable solution so that every person has access to health care.

Mr. Moody. Thank you very much.

Mr. Curtis.

STATEMENT OF RICK CURTIS, DIRECTOR, POLICY DEVELOPMENT AND RESEARCH, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. CURTIS. Thank you. I am Rick Curtis, director of policy development and research with the Health Insurance Association of America. Our members insure approximately 95 million Americans.

I would like to start by emphasizing, as Mr. Tresnowski did, that small group market reform is not a panacea. It will not solve the problem of having over 30 million uninsured Americans. That is true not only because of the health care cost problem, but also because the vast majority of uninsured Americans are not in a position to afford health care coverage without assistance. I point to 2 or 3 basic facts. Approximately 2 out of 3 uninsured workers in this country have individual wages of under \$10,000 a year; 6 out of 10 uninsured Americans have family incomes of under 200 percent of poverty; and if you look at the average payroll—or the take-home pay of the proprietor—of small businesses who do not offer coverage, they are substantially lower than those of small business who do offer coverage. The uninsured issue is to some substantial degree simply an economic issue. Those who cannot afford coverage do not and will not obtain coverage without the financial assistance from Government that they need.

Our membership has over the last 3½ years developed a comprehensive set of proposals for extending health care coverage access to all Americans. A key component of our proposal is small employer market reform. As you well know, the uninsured worker population is heavily concentrated in this market. Our overall rules for marketplace behavior are virtually identical with those agreed to by Blue Cross and Blue Shield. All small employers should have private coverage guaranteed available to them. Entire groups should be covered. Employers or insurers shouldn't leave out individuals because they are sick. They should not be canceled because of adverse health experience. There should be continuity of coverage so that if an employer changes carriers or an individual changes jobs, if someone was covered for a condition—already fulfilled a preexisting condition requirement, for example—they should not be left out from that point on, as long as they stay in the employer-sponsored health insurance system. And there should be premium pricing limits, relative pricing bands, and we also support the NAIC approach. We have a somewhat simpler proposal than the NAIC's—National Association of Insurance Commissioners—but the net effect is virtually identical.

Now, we have, as Mr. Tresnowski noted, some differences in the precise design, the applicability, and the role of reinsurance, and some differences on the methods of guaranteed availability. But let me assure you that we have no differences about how Federal statutes should or should not deal with that. Those issues should be left to the State level.

We don't know the precise numbers and, more particularly, the risk profile of insured vis-a-vis uninsured small employers on a State-to-State basis. The financial experience of reinsurance, as just one example, will vary substantially according to the precise characteristics in the State, and no one has the data to precisely project such experience at this point in time. This approach has to be tried, has to be experimented with, and has to be refined as there is experience.

We also have some differences with the Group Health Association of America. For example, we think that periodic choice of participation in reinsurance would lead carriers to come into reinsurance in years where they have a worse-than-average risk profile and stay out of reinsurance in the years when they don't. That would create an adverse selection spiral in terms of the reinsurer's cost experience, and narrow its base for spreading risks.

There are a number of other issues that are germane here. Let me mention one specifically because in earlier testimony Mr. Etheredge suggested moving to a uniform billing form. Along with a number of other organizations, including the Blue Cross and Blue Shield system, we have been working through the American National Standards Institute to develop a uniform electronic billing format. A final draft form will be put forward in early 1992 and be pilot tested. This is an approach that we believe can achieve efficiencies, not only for private payers but also for hospitals and physicians as well.

I stand ready to answer any questions you have. Thank you for the opportunity to testify.

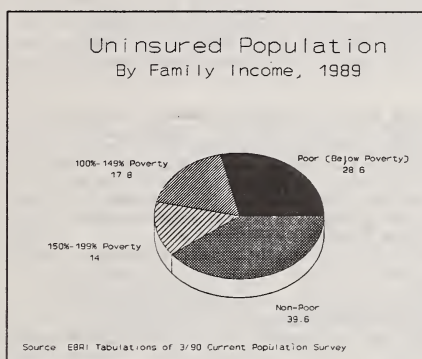
[The prepared statement follows:]

STATEMENT OF RICK CURTIS, DIRECTOR, POLICY DEVELOPMENT AND RESEARCH, HEALTH INSURANCE ASSOCIATION OF AMERICA

I am Rick Curtis, Director of Policy Development and Research, Health Insurance Association of America. The Health Insurance Association of America (HIAA) is a trade association of 300 private health insurance companies which provide health insurance for 95 million Americans.

In 1989, the latest year for which we have data, all private insurers covered 76 percent of the population or 189.0 million out of 249.9 million Americans. Persons covered either by private or public health insurance totalled 216.6 million. In 1988 private health insurers in the United States paid over \$170 billion for medical care and disability claims. This is indeed a significant achievement.

But, clearly there is a gap between those covered and the total population. HIAA member companies (and Blue Cross/Blue Shield) don't cover every American - nor can they. A profile of the uninsured will explain this particular dynamic. These numbers frequently don't get the attention they merit and require if all of us participating in the debate truly want to come up with some workable solutions.



As the above chart shows, in 1989, approximately 28.6 percent of the poor were below the federal poverty level; 17.8 percent had incomes between 100 percent and 149 percent of poverty; 14 percent were between 150 and 199 percent; and 39.6 percent had incomes 200 percent or more above poverty. Of those with family incomes below the Federal poverty level, Medicaid reaches only 42 percent of them.

The Health Insurance Association of America developed its proposal on access only after a very exhaustive analysis of the data just provided and collateral data on cost and industry practices. HIAA believes that only through a combination of efforts between the public (federal and state) and private sectors can we hope to stabilize the present and improve access into the future.

We've broken down our multi-point program into three parts: actions we can take, actions you as federal legislators can take and actions appropriate for state action. The three taken together will achieve the objective of access for all Americans.

INDUSTRY STEPS

For more than three years, HIAA wrestled with perhaps one of the most complex parts of the access equation -- the small employer market. The small employer market provides one of the

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most vivid examples of how health care cost inflation continues to afflict our financing system. Faced with unrelenting demands to hold health care costs down, insurers and employers have intensified the search for ways to moderate premium increases. Leaving high-risk individuals out of group coverage has been one such response. The "excessive employer churning" that newspaper accounts often bring to our attention is largely a function of employers seeking the lowest available rate. We, too, constantly hear the charge by small employers that the presence of a high-risk individual in their group has made it impossible to obtain coverage at any price.

This dynamic is complicated further by the tumultuous labor market of the small employer. Small employers are far more likely than larger organizations to go in and out of business. Our own annual employer survey suggests that employees of small firms also are more likely to change jobs. Employee turnover among small, insured firms is about 23 percent annually and is twice that level for small employers without coverage. These factors contribute to the reluctance of such employers to offer coverage as well as the difficulties of serving the market.

As the complexities of the small employer market have grown and the likelihood of individuals' being separated from the financing system has increased, there is a growing perception that even if they have coverage, they stand a reasonable chance of losing it if they change employers, or if they have poor claims experience.

Mr. Chairman, we recognize that substantial small employer market changes are needed if we are to serve the longer-term interests of small employers and meet the concerns of policymakers. This February the HIAA Board reaffirmed its commitment to the comprehensive set of recommendations that we believe can be achieved in the context of a viable private marketplace. The essence of our proposals is to make certain changes in the market to provide substantially more predictability and protection to the purchasers of coverage. Let me emphasize that, to work, these changes will have to apply to all players in the small employer market. All competing entities in the small employer market, including non-insured benefit plans, would have to be bound by the same rules in order to prevent any company or segment of the market from being placed at a disadvantage.

The small employer market precepts we recommend are:

1. If a carrier chooses to cover an employer group, it would be required to accept the whole group. Individuals could not be excluded from coverage within the group for health reasons.
2. At renewal time, employer groups and/or individuals within these groups would be assured that their coverage would not be canceled because their health had deteriorated.
3. Given the frequency with which small employers change carriers and employees in this market change jobs, individuals should have greater protection when making such moves. Therefore, when individuals are covered in the system, they would not have to face new preexisting condition restrictions, once those requirements have been fulfilled, in the event that they change jobs or their employer changes carriers.
4. There should be meaningful limits on how much an insurance carrier's rates could vary for employer groups of similar composition (similar demography, geography, benefit design and industry). This also would involve limits on how much a carrier could raise its rates for a specific group above and beyond general increases in trend factors.

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5. Insurance carriers would retain the right to medically underwrite for purposes of assessing risk and setting rates but not to exclude individuals from coverage in a group plan.
6. Finally, a major objective of these reforms should be to ensure a viable private marketplace over the long term.

These precepts were adopted by the Board with the understanding that they will exact some pain from the industry in the short term, but are critical for coverage of the small employer over the longer term. They represent our industry's commitment to meeting the needs of the small employer community by providing a responsive insurance marketplace.

To give effect to these proposals, state governments must authorize a private not-for-profit reinsurance organization. Otherwise, these reforms are not achievable. This organization would allow carriers to pay a premium in exchange for having the reinsurer bear the risk for reinsured individuals. Consistent with the small employer market changes, the proposal does not envision breaking up groups for purposes of reinsurance. Rather, insurers would treat all individuals in a group the same way; all members would have the same benefits. The reinsurer would stand behind the carrier and simply reimburse for claims associated with reinsured individuals. This will allow us to assure that high risks are spread, broadly through the private market rather than concentrated in one small employer group.

The reinsurance mechanism naturally would sustain financial losses or shortfalls, since carriers would reinsure only persons whose claims are expected to exceed the price of reinsurance. The intent of the proposal is that losses be financed privately. Losses first would be spread across carriers in the small employer market through an assessment of up to four percent of premium, except in states where general funds would be dedicated for this purpose. If losses were not absorbed fully by the small employer market, a second tier of losses would be spread more broadly.

These proposals will assure that no small employer, and no employee of a small employer, will be turned down for health insurance because of poor health. They will restore the concept of pooling risk across large groups, greatly limiting how much of the cost of poor health must be borne by the individual employer. Further they will moderate significantly the sometimes dramatic premium increases now experienced by small employers at renewal time and thereby reduce the incentive to change carriers frequently.

With our recommended market changes in place, the small employer will stand to benefit greatly from our rapidly evolving cost management capacity. These reforms will encourage competition based on efficiency rather than selection. Competitors would no longer be allowed to draw business away from more efficient health benefit plans by offering temporarily low prices that skyrocket once an employee gets sick. Insurers that reduce inefficient administrative costs and that offer cost-effective financing systems and delivery networks will gain a larger share of what is an extremely price-sensitive market.

A full summary of the HIAA proposal is attached to this statement.

Using these precepts as a base, we've developed model legislation that we believe state legislatures can and should adopt to implement small market reforms.

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STATE STEPS

In adopting our model bill, the states will establish a reinsurance entity to permit carriers to spread losses for high-risk small groups equitably across the market. Under the HIAA proposal, no employer would have to pay more than 150 percent of the relevant market averages for basic coverage.

For the medically uninsurable individuals who are not part of an employer group, we advocate the creation of state risk pools. Losses should be financed by state general revenues or other broad based funding. If a state does not act, the U.S. Department of Health and Human Services should be authorized to set up a federally funded pool in that state to pay for losses. The funds for the pool would come from funds that HHS would otherwise spend in that state.

State risk pools are designed to guarantee the availability of individual private health insurance to all Americans under age 65 who want to purchase protection but who are not considered to be insurable for health reasons. At this time 33 states have enacted, or are considering, legislation establishing state risk pools.

Those states which have established risk pools include:

California	Colorado
Connecticut	Florida
Georgia	Illinois
Indiana	Iowa
Louisiana	Maine
Minnesota	Mississippi
Missouri	Montana
Nebraska	New Mexico
North Dakota	Oregon
Rhode Island	South Carolina
Tennessee	Texas
Utah	Washington
Wisconsin	Wyoming

There are other steps we also believe states should take to improve access such as repealing state statutes that stand as obstacles to managed care arrangements.

The HIAA is aggressively pursuing legislation affecting small groups at the state level. Virtually all of the 49 states in session for 1991 are currently studying the problem of the uninsured or have introduced legislation targeted at the problem. The HIAA has testified in 41 states regarding possible solutions to the growing number of uninsureds and has reported over 500 bills to its membership.

The NAIC is also actively involved with legislation at the state level. Model legislation on small group rating and renewability has been adopted by the NAIC and has been enacted by, or passed at least one legislative body, in Arkansas, Indiana, Florida, North Dakota, New Mexico and South Dakota. At its April 1991 meeting the NAIC proposed two model bills for further consideration aimed at assuring the availability of private insurance to all small employers and assuring the stability of the small employer health insurance market.

Legislation at the state level generally falls into one of the following categories:

1. comprehensive small employer market reforms and reinsurance structures;
2. rating and renewability requirements;

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3. state sponsored health coverage; and
4. employer mandates.

After three states, Oregon (1989), Kentucky (1990) and Connecticut (1990) enacted comprehensive measures, several states followed by introducing legislation affecting the small group market. For example, Alaska, California, Maine, Minnesota, Nebraska, New Jersey, New York, Ohio, Texas, Vermont and Wisconsin have introduced comprehensive small group reform packages. These bills encompass a broad spectrum of proposals which would impact rating, underwriting, benefits and reinsurance. The Ohio Department of Insurance has established a commission to study small employer market reforms. This commission, "Access Ohio", recently issued its report calling for a number of legislative initiatives.

Other states which have introduced a typical legislation focusing on the uninsured include Arizona, Alaska, Colorado, Iowa, Louisiana, Massachusetts, Michigan, Mississippi, North Carolina, South Carolina, South Dakota, Vermont and West Virginia.

To encourage small employers to offer health insurance, Arkansas, Florida, Georgia, Illinois, Kentucky, Maryland, Minnesota, Missouri, Rhode Island, Virginia and Washington have passed legislation which exempts policies issued to small employers from certain state mandates. This type of legislation has also been introduced in Arizona, Kansas, Montana, Nevada, New Hampshire, Ohio, Tennessee and Texas.

State regulators also have been actively confronting the issue of the uninsured. For example, the New York and Pennsylvania Insurance Departments have both issued regulations restricting the underwriting practices for small groups (e.g. denying coverage to certain occupations and unhealthy individuals within the group).

HIAA anticipates that many more states will enact legislation affecting small employer groups during the remaining portion of their 1991 legislative sessions.

FEDERAL STEPS

We call on the federal government to take the following steps:

- extend to all insured plans the same exemption from state mandated benefits enjoyed by large self-insured employers.
- help small business by extending to the self-employed the 100 percent tax deduction for health insurance.
- target new tax subsidies to financially vulnerable groups.
- restore the promise of Medicaid for the poor and near poor by expanding Medicaid to cover all those below the federal poverty level.
- extend the Medicaid "spend-down" program to all states and set eligibility thresholds so that no one is impoverished by medical expenses.
- allow low-income individuals above the poverty level to "buy into" an income-related package of primary and preventive care services.

- direct the Secretary of Health and Human Services to establish a state pool for uninsurable individuals in any state that fails to do so.

COST CONTAINMENT

No one single step can achieve on its own the results we all seek. Just as we must take those steps necessary to improve and reform access to care, so too must we come to grips with perhaps one of the most significant components to the problem -- cost.

During the past five to ten years, the health care delivery and financing system in this country has evolved at an impressive pace. The most visible change has been the explosion of what are becoming known as managed care delivery systems, of which HMOs and PPOs are the best known.

Managed care embraces a variety of existing and developing structures. It may be defined as those systems that integrate the financing and delivery of appropriate health care services to covered individuals by means of the following basic elements:

- arrangements with selected providers to furnish a comprehensive set of health care services to members;
- explicit criteria for the selection of health care providers;
- formal programs for ongoing quality assurance and utilization review; and
- significant financial incentives for members to use providers and procedures associated with the plan.

In 1989, one out of three employees had health coverage provided through an HMO or PPO. Enrollment in HMOs has more than doubled between 1983 and 1989. There were approximately 33 million Americans in HMOs in 1989 or approximately 13.2 percent of the population. When we calculate in point-of-service plans (generally PPOs), and managed fee for service, the number of Americans covered by some form of managed care would approach 75 million.

Continued growth and use of managed care arrangements represent our best hope of reigning in health care costs. Moreover, managed care, as contrasted with an all payer system of rate setting, is more, not less, likely to achieve cost control results without the kind of economic disruptions associated with rate setting.

CONCLUSION

A constructive national debate, predicated on a rational discussion of the dynamics of our health care system, can be founded on an approach which recognizes that each of the three players - the federal government, the states and the private sector - has a responsibility to meet. The health insurance industry has developed its action plan with this concept as its cornerstone. We are prepared to work with each of the other players to achieve a responsible and more affordable health care system for all.

(April 5, 1991)

**HEALTH INSURANCE ASSOCIATION OF AMERICA
PROPOSAL ON PROVIDING HEALTH CARE FINANCING
FOR ALL AMERICANS
(In Detail)**

Today, more than 30 million Americans have neither public nor private health care coverage. These Americans often have greater problems gaining access to the health care system than do those who have coverage. They may forgo necessary care or delay getting treatment until their problems worsen --- and become more costly.

These individuals represent the widening gap in our nation's health care financing system. The Health Insurance Association of America (HIAA) believes that policy makers must devise ways to close the gap. More precisely, government action is needed to provide the legislative and fiscal base that will enable a combination of public and private providers of health care coverage to meet the health care financing needs of all Americans.

The HIAA proposal takes into account the important policy implications of the relationship between income, the workplace and health care coverage. The vast majority of Americans with adequate incomes have health coverage. Ninety percent of all nonelderly Americans with incomes of over three times the poverty level have some form of coverage. Approximately 150 million nonelderly in this country obtain health coverage through an employment-based plan.

Yet most individuals without health care coverage are in families with some attachment to the work force. In fact, 66 percent of the uninsured are full-time workers or are dependents of full-time workers. Another 14 percent either work half-time (18 to 34 hours a week) or belong to families with one or more part-time working members. (Current Population Survey, U.S. Dept. of Health and Human Services, March 1988 tabulations)

Efforts to make coverage more available and more affordable should take into account the fact that most Americans receive their health care coverage through employment. A realistic approach is to focus on improving the ability of financially vulnerable employers to offer health insurance to their often low income employees. In addition, low-income employees need direct government assistance so that they can afford their share of premiums.

To be cost effective, expansion strategies should build on existing coverage and target public coverage to the poor and near poor. Extending public coverage to higher income individuals will inevitably lead to unnecessary tax increases to support substitution of public coverage for private coverage.

Finally, HIAA also believes that efforts to expand the nation's health care financing system must be complemented by responsible cost-containment measures. HIAA's policy on cost containment includes an emphasis on the development of managed health care systems. It also calls for greater scrutiny of one of the major causes of high costs ---the use of new, often unproven technologies and procedures. We also strongly supports wellness and prevention activities, as well as economic incentives for the consumer to be "cost conscious" in the use of medical resources and in choosing a health plan. A more detailed discussion of HIAA recommendations follows.

I. ADOPT REFORMS TO ASSURE THE AVAILABILITY AND RELIABILITY OF PRIVATE HEALTH INSURANCE COVERAGE.

The small employer health benefit market is receiving increasing attention. This is largely because a high proportion of workers without health care coverage --- fully two-thirds --- work for an establishment with 25 or fewer employees at that business unit's location. This is not surprising since only one in three firms with fewer than 10 employees offers health benefits.

Increasingly, small employers seek relief from rising health care costs by an aggressive search for the lowest possible price for health care coverage. Those with healthy employees are more likely to seek, and obtain, coverage at prices that reflect their low risk.

In turn, more and more insurers have found that to be price competitive for these low risk employers, they are less able to spread the costs of groups with employees at high risk of incurring large medical expenses broadly across the lower risk groups. This has led to a growing number of higher risk employers that cannot find coverage at an affordable price. Moreover, those employer groups that are lower risk today and thus initially obtain a lower premium, will likely have employees that develop expensive medical conditions. Those employers may face large premium increases when their experience deteriorates.

In general, then, small employers have greater difficulty than large employers in affording and sometimes even obtaining health coverage. Furthermore, the greater frequency with which small employers change carriers and their workers change jobs exposes individuals in this market to greater risk of being left out of the system. Finally, small employers are highly sensitive to very large, unanticipated premium increases and may fail to initiate or retain coverage in a marketplace where individual employer experience is highly unpredictable.

We have now reached the point where substantial small group market reforms are needed if health insurers are to serve the broader interests of small employers and their employees. HIAA has developed and is recommending a comprehensive set of legislative reforms that we believe can be implemented while allowing a viable private marketplace.

• Small Employer Market Reforms

HIAA recommends market reforms and reinsurance recommendations that would ensure fair access to, and continuity of coverage for, small employers and their employees. When enacted by the states, these reforms will introduce a greater degree of predictability and stability to the small employer health benefit marketplace.

- Guaranteed Availability. All small employer groups would be able to obtain private health insurance regardless of the health risk they present.

The HIAA proposal would require the "top ten" carriers in a state (defined by their small employer market share) to guarantee to issue health care coverage to any legitimate small employer group. Other carriers would be strongly encouraged to guarantee to issue coverage through favorable reinsurance terms.

- Coverage of Whole Groups. Coverage would be made available to entire employer groups; No small employer nor any insurer would be able to exclude from the

group's coverage individuals who present high medical risks.

- Renewability of Coverage. At renewal time, employer groups and/or individuals in these groups would be assured that their coverage would not be canceled because of deteriorating health.
- Continuity of Coverage. Once a person is covered in the employer market and satisfied an initial plan's preexisting condition restrictions, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers.
- Premium Pricing Limits. Insurance carriers would be required to limit how much their rates could vary for groups similar in geography, demographic composition and plan design.

More specifically, a carrier's premiums for similar groups could not vary by more than 35 percent from the carrier's midpoint rate (halfway between the lowest and highest rate). There would also be a 15 percent limitation on how much a carrier could vary rates by industry. Finally, carriers would have to limit a group's year-to-year premium increases to no more than 15 percent above the carrier's "trend" (the year-to-year increase in the lowest new business rate). Separate trends should be allowed for managed care and non-managed care to reflect health care cost/efficiency differences in these structures.

In order for the reforms to succeed, the implementing legislation will have to pertain to all competitors in the small employer market. If any one company or segment of the market pursues such reforms independently, without rules for marketplace behavior spelled out in legislation, it might invite financial ruin. It is therefore important that federal law give states clear authority to impose these rules on all competitors in the small employer marketplace. Within the scope of these rules, insurers would be allowed to use individual risk assessment and classification initially to assess risk, to set rates, and to determine which individuals for whom to purchase reinsurance.

Private Reinsurance

A private marketwide reinsurance system would make these small employer reforms possible. Reinsurance means to "insure again." Under reinsurance, an insurance company, called the ceding or direct-writing insurer, purchases insurance from the reinsurer to cover all or part of the loss against which it protects its policyholder. The reinsurer is, in a sense, a silent partner of the original insurer. Reinsurance enables an insurer to accept a greater variety of risks. By sharing these risks with a reinsurer, the ceding insurer obtains an adequate spread within which the law of averages can operate.

Reinsurance will allow individual insurers (or other small employer health plan entities) to implement reforms without facing high financial losses. Reinsurance will allow carriers to assure small employer groups presenting a high health risk access to a basic set of benefits at a rate no higher than 50 percent above the applicable average market premium. For groups already covered by an insurance carrier, the premium pricing limits described above would pertain, and would in many cases limit a high risk employer's rates to a level below the guaranteed marketwide maximum level of 50 percent above average.

Under the approach developed by HIAA, the "top ten" carriers in a state's small employee health benefit market (defined by small employer premium) would be required to guarantee to issue health coverage to any legitimate small employer group applicant. Other "non top ten" carriers would not be required to guarantee issue coverage but would be strongly encouraged to do so through better reinsurance terms for guaranteed issue carriers. Guaranteed issue carriers could: (a) reinsure entire high-risk small employer groups at a reinsurance premium price of 150 percent of average market costs or (b) reinsure high-risk individuals within groups at 500 percent of average market costs. (Individual reinsurance would include a \$5,000 deductible.) To reduce the volume of reinsured claims, reinsurance would be on a three-year basis. (If reinsurance were permitted annually, carriers would declare more groups or individuals high-risk and utilize reinsurance more often increasing reinsurance losses to unacceptable levels.) Nonguaranteed issue carriers would only be permitted to reinsure new entrants to existing groups through individual reinsurance. This reflects the fact that under the "whole group" rule, all carriers would have to make coverage available to any new employees entering a group they already insure.

The reinsurer would cover the costs associated with reinsured cases. The process of reinsurance is invisible to employers and employees and is purely a transaction between the ceding insurer and the reinsurer.

Because reinsurance would be aimed at employer groups and employees known to be high risk, and because the premium price would be limited in order to encourage carriers to accept high risk applicants, in the aggregate the cost of reinsured persons will exceed the reinsurance premiums. Under the HIAA proposal, the reinsurer's losses would be spread equitably across all competitors in the private marketplace--both the guaranteed issue and nonguaranteed issue carriers.

The losses would be covered first through contributions from all carriers in the small employer market. If losses were significantly higher than expected, a second "safety valve" of broad-based financing will be made available.

HIAA will aggressively pursue reinsurance and related small employer market reform at the state level. HIAA will also recommend Federal legislation to give states the authority, where necessary, to assure compliance with the market reforms outlined here and to finance the reinsurance system.

Establish State Pools for Uninsurable Individuals

Even with increased employer-based coverage and with Medicaid expansions (see below), medically uninsurable individuals who are not part of an insured employer group would remain without coverage.

High-risk pools should be established to make coverage available to such individuals. Pool losses should be funded by general revenues or similar sources, which spread the cost broadly across society.

As of December 1990, 25 states have enacted broad-based pools for uninsurable individuals.

II. ALLOW INSURERS TO OFFER MORE AFFORDABLE BENEFIT PLANS TO SMALL EMPLOYER GROUPS.

Over the years, the list of state laws mandating benefits and providers has grown dramatically. There are about 800 such laws nationwide --- and they mandate coverage of disparate services and provider categories such as chiropractic and podiatric services, acupuncture, expansive inpatient mental health services even where most cost effective alternatives exist, in vitro fertilization and pastoral counseling. The cumulative effect of this hodgepodge of state laws is to increase the cost of health insurance, particularly to small employers who are most in need of affordable basic benefits and who are too small to self-insure and thus escape these mandates as larger employers often do.

One reason that mandated benefit laws increase the cost of coverage is that multi-state insurers must monitor and comply with so many different state rules and regulations. Insurers are precluded from developing lower-cost prototype plans that would be marketable across state lines. Instead, they are often forced to offer only "Cadillac" plans based on a multitude of mandates from many states.

Many of these benefits, are expensive in their own right. Taken together, mandated benefits in many states provide a package that many small employers simply cannot afford.

A 1989 study conducted by Gail Jensen, then a University of Illinois health care economist and now at the University of North Carolina, concluded that 16 percent of small employers not now providing health insurance would offer benefits in the absence of state mandates.

State-mandated benefit laws do not apply equally to all employer sponsored health plans. The Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from state mandated benefit laws and other forms of state insurance regulations. In general, only large employers have the financial resources or the risk-spreading base to self-insure; self insurance allows multi-state employers not only to save administrative costs through plan uniformity but to pick and choose those benefits that are most desirable and cost effective. Ironically small employers with limited income do not have this flexibility. Employers too small to self-insure do not have this flexibility, and they are thus less likely to offer health insurance at all.

In 1985, the U.S. Supreme Court ruled that to put employee health benefit plans on the same footing as self-insured plans required congressional action. Moreover, in recent years, there also has been a proliferation of state actions that obstruct or hinder private sector managed care efforts that would make health care coverage more affordable. These state bills are aimed at limiting contractual arrangements with cost-effective provider networks, as well as preventing or limiting insurers' ability to carry out effective utilization review programs. Again, small employers should be able to benefit from the same cost-management approaches as do larger employers.

III. PROVIDE TARGETED TAX ASSISTANCE SO THAT SMALL EMPLOYERS AND THEIR FINANCIALLY VULNERABLE EMPLOYEES CAN AFFORD HEALTH INSURANCE COVERAGE.

Small businesses tend to be younger, financially less stable and employ a lower wage work force. Thus, health benefits

often represent a greater financial burden to small businesses, who are far less likely to offer them than are other employers. A 1989 HIAA survey found that only 33 percent of firms with fewer than 10 employees offer health benefits. Conversely, over 96% of firms with more than 25 employees offer health benefits.

Eleven percent of uninsured workers are self-employed. They are uninsured in part because self-employed workers receive only a 25 percent income tax deduction for the cost of health benefits. Other (incorporated) businesses receive a full 100 percent deduction.

The financial vulnerability of small employers and uninsured workers, as well as government fiscal realities, suggest that additional tax assistance should be carefully targeted to those populations most in need. For instance, government should:

- Direct new tax subsidies to assist employers and individuals with inadequate financial resources (e.g., certain small employers) in purchasing private coverage. Sliding scale subsidies should be targeted, for example, to small employers paying average wages of less than \$18,000 annually. The subsidy rate for such employers should increase as the percent of total payroll going to hospital and medical benefits increases. A temporarily higher subsidy could be given to firms offering benefits for the first time;
- Target subsidies to low-income individuals and families. A refundable tax credit equaling 50 percent of the employee share of premium cost could be made available for taxpayers at or below the poverty level. (A ceiling on qualifying premium costs would equal the median employee share of premium for employer-sponsored coverage nationally or about \$360 for individual and \$800 for family coverage in 1989. Above poverty, the percentage credit would decrease as income rises and phase out completely at twice poverty. Advance payment of the tax credit through the employer should be made for employees with little or no income tax liability; and,
- Extend to the self-employed the 100 percent tax deduction enjoyed by other employers (as long as they provide equal coverage for their employees, if they have any).

IV. EXPAND PUBLIC COVERAGE FOR THE POOR AND NEAR POOR.

Thirty percent of the uninsured have family incomes below the federal poverty level (\$10,560 for a family of three in 1990). Another 17 percent have family incomes between one and one and a half times the federal poverty level. The current federal/state Medicaid program covers only four out of ten poor Americans. Many states do not have a medically needy program, and Medicaid income eligibility thresholds for the non-elderly generally fall far below the poverty level.

Because the poor and many of the near poor do not have the means to purchase coverage on their own, the health care financing responsibility for these populations rests largely with the government. HIAA proposes the following actions:

- The Medicaid program should be extended to cover all poor Americans regardless of age, family structure or employment status. To carry out this recommendation

fully, Medicaid eligibility will have to be independent of cash assistance programs such as AFDC. Moreover, fiscal constraints suggest first priority should be phasing in coverage to all poor children under age 18.

- For poor workers with access to employer-based private coverage, HIAA supports appropriate state implementation of recent federal legislation regarding a "buy-out" employed individuals and their families from the Medicaid program. States should pay the poor employees' premium contributions and cost sharing (co-pays and deductibles) associated with available employer plans when Medicaid outlays would be reduced on an average per capita basis. This will help ease individuals' transition into economic self-reliance and often improve access to medical care.
- Near-poor individuals with family incomes between one and one-and-a-half times the federal poverty level should be allowed to "buy in" to a package of primary and preventive care services only. Limited premiums would be based on a sliding scale related to their income. This would target government assistance to the primary and preventive services the near poor most often forgo and for which employer sponsored plans cost-sharing sometimes presents a financial obstacle for the near poor population.
- To assure that no American falls beneath the poverty level as a consequence of medical expenses, all states should deduct medical expenses from income when determining eligibility for Medicaid. "Medically needy" or "spend-down" programs (and many states have already adopted such programs) constitute a last-resort financial safety net covering a full range of health services.

Raising eligibility standards for Medicaid to 100 percent of the federal poverty level will give an estimated 9.5 million to 11 million uninsured Americans access to Medicaid coverage. (The Medicaid program currently pays for the care of over 21 million people annually.) While costly, these reforms would increase Medicaid costs by only about 25 percent while increasing the population served by the program by about 70 percent. This is because three quarters of Medicaid spending now goes for long-term care and other services for the elderly and disabled. Medicaid coverage for poor uninsured populations is far less expensive on a per capita basis.

V. IMPLEMENT STRATEGIES TO CONTAIN HEALTH CARE COSTS

Efforts to improve access will be thwarted, at least to some extent, if we cannot find a way to constrain escalation of health care costs. As the cost of care continues to rise, employers who are on the margin with respect to decisions to offer coverage will find coverage unaffordable. Solving the cost problem is a prerequisite to solving the access problem.

- Although there are no simple solutions to the cost problem, a key component of any effective cost containment strategy is the further development of managed care systems of financing and delivery --- HMOs, PPOs, point-of-service plans, and the like. Since physicians make most of the key decisions that determine how expensive treatment will be, it is imperative to make sure that patients get care from physicians (and other providers) who use resources

efficiently. Managed care systems build on that premise by selecting panels of providers for their networks who meet specified criteria and who agree to be monitored to assure that they continue to provide high-quality cost-effective care. Patients are then given financial incentives to choose these providers as their caregivers. By integrating the financing and delivery of care, managed care improves quality while constraining costs.

- A second major element in effective cost containment must be improved knowledge about what constitutes cost-effective care. New technologies that promise better care are often introduced into medical practice, often at great cost, before anyone has made a careful assessment of their cost-effectiveness. They may be better, but is the extra benefit sufficient to outweigh the extra costs? Insurers, government, and all who pay for medical services have a stake in developing better mechanisms and procedures for answering that question about new technologies and procedures.
- Related to the need for better knowledge about technologies is the need for better information about what constitutes good medical practice. There are many areas of medicine where there is broad variation in the way patients are treated even when their conditions vary little. Physicians often have insufficient information to know what constitutes cost-effective care. Increased efforts should be directed to filling this knowledge gap by establishing mechanisms and financing to develop medical practice guidelines and protocols which define the range of acceptable medical practice for particular conditions. The task is so large that it will require a large commitment of resources, from both government and the private sector. Providing these kinds of advances in medical knowledge will help to improve utilization review activities by providing standards that are accepted by both physicians and, very likely, the courts as well.
- As implied, government also has a vital role to play in the battle against costs escalation. Government has a key role, particularly with respect of funding, in technology assessment, in protocol development, and in collecting and analyzing data that can be used to develop more accurate measure of cost, use, and medical outcomes. Government also needs to create a legal climate that is hospitable to the growth of managed care, which means not limiting insurers' ability to employ appropriate utilization review techniques and not outlawing managed care plans that require patients to pay significantly more when they opt to get care from non-network providers and thus generate significantly higher costs.
- Government can also help to reduce administrative cost by encouraging and cooperating with industry-wide efforts to utilize common claims forms and greatly expand electronic collection, analysis, and payment of claims. Finally government has to take the lead in malpractice reform, which has two components: (1) reducing the incidence of malpractice by encouraging better risk management activities by providers and by policing provider ranks to assure that only competent providers treat patients, and (2) by making legislative changes in the malpractice system to assure that awards are appropriate and that the process of adjudication does not absorb an excess percentage of the costs of righting the wrongs done to patients.

Mr. MOODY. Thank you very much. All three of you will have your entire statements included in the record. Of course, the staff has been scrutinizing your comments already.

Let me ask you, Mr. Curtis, do you agree that redlining takes place with regard to certain groups? We understand that is a fairly common practice.

Mr. CURTIS. In the current marketplace, that is true. Individual carriers often have their own set of rules for what kinds of groups they will cover or not cover. Under our reform proposals, all small employers, regardless of industry, regardless of occupation, would have access to private coverage, and we would put severe limitations on how much rates could vary by industry. The rates could vary by no more than 15 percent from what the rate would otherwise be, regardless of how risky the occupation or industry is.

Mr. MOODY. Do all three of you agree that the smaller the risk pool, the higher the actuarially required premium must be to be mathematically correct? Because as the risk pool shrinks, the variance goes up. It is a mean versus variance problem in statistics, the law of large numbers. So as the risk pool gets larger, the smaller the variance and therefore the smaller the necessary premium to cover the risk. If that is the mathematical properties of large versus small risk pools, how do we, in spite of all the other things that we have to cope with, how do we deal with the small employer problem without some form of cross-subsidy to the larger employer problem? Unless, in fact, you can figure out ways of pooling the entire risk through universal or some other coverage.

Mr. CURTIS. There are, of course, Mr. Moody, large numbers of people who are employed by small businesses.

Mr. MOODY. Right.

Mr. CURTIS. The reason we are proposing a reinsurance mechanism is that it is an approach that can pool those large numbers of people and those risks across a large base.

The difference, really, that is pertinent here is that half of small employers do not now purchase coverage, and we may have some substantial problem with systemic adverse selection as those employers who come into the system for the first time probably will have a worse risk profile.

We think, however, that the system can pay for itself internally. We don't think that problem will be too severe. However, in some States, it may be, and we would then need to look at a broader basis for spreading losses that result from that kind of systemic adverse selection.

Mr. MOODY. Let me interrupt. Are you suggesting that reinsurance is the way to handle it but that it should be mandatory?

Mr. CURTIS. Our preference is that, yes, all players in the small employer marketplace should participate in reinsurance.

Mr. MOODY. Should insurance itself be mandatory?

Mr. CURTIS. In order for reinsurance to work, anyone who can take advantage of reinsurance has to help pay for it through assessments. Otherwise, it cannot work.

Now, we understand that in some States there may be exceptions, for example, for a very large HMO or for an HMO plan that wishes to internalize the risk that has a very large market penetration.

Mr. MOODY. Right.

Mr. CURTIS. But our position is that to the maximum degree everybody in the small employer marketplace should participate because it provides the broadest basis for spreading risk.

Mr. MOODY. So would this be a version of the so-called play or pay formula where every company has to either have coverage and avail itself of reinsurance or pay into some sort of State pool, a State-administered risk pool?

Mr. CURTIS. No.

Mr. MOODY. I mean, your plan is that everyone be covered in small businesses, right?

Mr. CURTIS. Our plan is that all small businesses have access to private coverage just as under the Blue Cross and Blue Shield system proposal. We are not proposing a mandate that all small employers purchase coverage.

Mr. MOODY. Right.

Mr. CURTIS. We are also proposing that all entities that provide coverage or administer coverage in the small employer market, including entities which Mr. Tresnowski referenced that are not now necessarily subject to State purview, be subject to these requirements and participate in reinsurance in terms of paying the assessments on nonreinsured cases to cover the losses for the cases that are reinsured. By design, our reinsurance system will lose money. It is a way again that insurers that take high-risk people can spread that risk more broadly across the market and protect any individual player against having a disproportionate amount of high-risk costs.

Mr. MOODY. How do we pick up that loss? Who pays for that?

Mr. CURTIS. Our approach is that there be an assessment on all nonreinsured business—the regular-risk business and the low-risk business if you will, in the small employer market—of no more than 4 percent. We think that this level will, in fact, be able to finance the losses for reinsurance.

We also call for a second tier approach, and we are open to a variety of options. One option might be an assessment across all health benefit plans, including those of larger employers. There are a variety of other mechanisms—

Mr. MOODY. So reinsure the reinsurer, in other words, reinsurance of reinsurance, in effect.

Mr. CURTIS. Yes, you could look at it that way.

Mr. MOODY. That safety net beyond the 4 percent.

Mr. CURTIS. Yes. But we think 4 percent will be adequate.

Mr. MOODY. It seems to me you have two issues here. One is high-risk individuals and whether it is the inherent higher cost premium required for smaller risk pools than for bigger risk pools. Those are not the same problem.

Mr. WALWORTH. I would tend to agree with you. I think that one of the approaches that we have to be very careful on in this is whether or not we are looking at the potentials of the large numbers and trying to create larger pools.

Mr. MOODY. Right.

Mr. WALWORTH. Or whether we are trying to create small pools of very high-risk individuals. I think those are two very distinct issues, and they present two very distinct problems to us.

Mr. MOODY. They are very different mathematical properties. Policy instruments should be designed accordingly.

It sounds like, Mr. Curtis, you are suggesting handling both issues with one instrument, the reinsurance instrument and a 4-percent premium to cover it.

Mr. CURTIS. Yes. The probability that any individual small group will have a higher risk profile is, of course, higher, just as the probability of variation in occupancy of a small hospital is higher, small versus——

Mr. MOODY. That is just a mathematical phenomenon.

Mr. CURTIS. Right. But if you look at the probability in aggregation——

Mr. MOODY. Right, that——

Mr. CURTIS [continuing]. In small groups of people, the probability is that a given percentage of those people will be high risk. It is no higher necessarily for 1,000 such people than a 1,000-person employer group that is together.

Mr. MOODY. With nine others.

Mr. CURTIS. Right. And through this approach, basically, you are providing a mechanism for identifying those high-risk people and spreading the risk broadly across that large number. So, yes, it does address both problems, I believe.

Mr. MOODY. Mr. Tresnowski, you had a point?

Mr. TRESNOWSKI. Yes. Mr. Moody, I just wanted to comment on the notion of reinsurance. You asked the question of Mr. Curtis whether it ought to be mandatory. I think it is extremely important to understand that reinsurance is a complicated concept and has not been tested. I believe it is inappropriate to say that it is a panacea for the problem of small groups. That is why we have argued that there should be a lot of variation and options for States guaranteeing access to small employers. In States like New York and Pennsylvania, a single carrier is prepared to take the entire risk and to enlarge the pool and to carry the risk of the pool under those circumstances. They can sustain this practice because they have a large market share, enjoy provider differentials, they don't pay premium taxes. In other States, the State may decide to allocate high risks to all of the carriers on some fair allocation basis.

The simple point is that there are a lot of ways to solve the problem that you described, and it doesn't have to be reinsurance. Another notion that people put in the category——

Mr. MOODY. There doesn't have to be reinsurance for those small free-standing firms?

Mr. TRESNOWSKI. That is right.

Mr. MOODY. And your suggestion is one big carrier might do it?

Mr. TRESNOWSKI. One big carrier might.

Mr. MOODY. Any particular carrier in mind?

Mr. TRESNOWSKI. You might allocate it out among a number of carriers. You might even go to a concept called stop loss. Wait and see what the risk is and when it reaches a certain——

Mr. MOODY. Will the New York and Pennsylvania experience give us data on which to make those judgments?

Mr. TRESNOWSKI. Oh, indeed.

Mr. MOODY. How far along is that?

Mr. TRESNOWSKI. Well, they have been at it for 30, 40 years.

Mr. MOODY. What is the result? I mean, what can you tell us?

Mr. TRESNOWSKI. The result is that they now have open enrollment, guaranteed availability with no underwriting restrictions. People do not have a problem in New York and Pennsylvania in accessing health insurance.

As I said in my opening comments, the problem is the price. If insurance is not purchased in these States, it is because of the price, not because of the availability.

Mr. MOODY. Right. But is the price tremendously different for individuals or companies based on the size of the individualized risk pool they are in?

Mr. TRESNOWSKI. Oh, yes, it is.

Mr. MOODY. That is the point of reinsurance. You can bring that down through reinsurance.

Mr. TRESNOWSKI. But they pool their small group market, but that price is still higher than, say, a large group of 10,000 or 20,000 size.

Mr. MOODY. Why would it be? Suppose you had one risk pool of, let's say, 100,000 people, and you had another risk pool of 100,000 people made up of 100 individualized firms of 100 each. Why would the joint risk pool of the—10,000 with 100 different firms be higher priced? Why would the individualized premium be higher, since the total risk pool would be the same? Why would the premium be higher in the former than in the latter case?

Mr. TRESNOWSKI. Because of the concept of selection. The smaller groups probably select insurance because they have a higher risk. In a large group of that number, you are taking everybody and you are taking that risk pool as it is.

Mr. MOODY. Just let me interrupt you. The selection on the part of the insurance company or the selection on the part of the employer of those employees?

Mr. TRESNOWSKI. The selection on the part of the employer.

Mr. MOODY. He would be selecting out higher risk people. But if you lose in a gigantic risk pool, he wouldn't have the same incentive to do so, would he?

Mr. TRESNOWSKI. No. They select the insurance coverage because they think they are going to use it, and you lose a lot of people who decide that they want to go bare because they have got a fairly good risk population.

Mr. MOODY. OK. So if you don't have mandatory insurance, you are still going to have people going bare.

Mr. TRESNOWSKI. That is right.

Mr. MOODY. But if they are in a large risk pool because they are part of this mechanism, then the incentive to go bare is more fairly reduced than if they are standing alone.

Mr. TRESNOWSKI. There is no opportunity to go bare because the entire group is enrolled.

Mr. MOODY. In New York and Pennsylvania?

Mr. TRESNOWSKI. Yes.

Mr. MOODY. No one can go bare in those States?

Mr. TRESNOWSKI. In a large group you either enroll the entire group or you don't enroll it.

Mr. MOODY. Right. No individuals can be selected out. But my point is that the incentive for going bare as a company would be almost negligible once you have your large risk pool coverage.

Mr. TRESNOWSKI. That is correct.

Mr. MOODY. Do those States allow them to write out individuals, to exclude an individual of high risk?

Mr. TRESNOWSKI. No, they don't.

Mr. MOODY. They don't.

Mr. TRESNOWSKI. They don't.

Mr. MOODY. You other gentlemen, do you care to comment on our dialog before we turn to Mrs. Johnson?

Mr. CURTIS. Again, I would just like to emphasize that in terms of any provisions in Federal law, I do not think we and Blue Cross and Blue Shield disagree at all. The States should have the authority to include all entities who participate in a small employer marketplace under these reform proposals and the authority to include them in a reinsurance mechanism. We are not proposing—and it is clear Blue Cross and Blue Shield would also oppose—any specificity in the Federal law as to how this sort of thing should be designed. We both agree there should be enhanced State authority to make it work.

Mr. WALWORTH. I think the only thing that I would add in terms of the discussion that has been going on is that you also cannot, in my judgment, separate the concept of pool and the pooling of risk, small group risk, from the issue of rating. If you have one very gigantic pool and it has a rate, that is the community rate.

Mr. MOODY. Right.

Mr. WALWORTH. And what you charge individual employer groups within that is where you get into issues of rate differences. That also is part of what causes decisions to be made by those employers as to whether or not they are going to participate.

Mr. MOODY. It is an economic decision.

Mr. WALWORTH. That is right.

Mr. MOODY. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

In describing the position of apparently both HIAA and Blue Cross and Blue Shield in supporting certain reforms of the small group market, such as guaranteed availability, no cancellation, no exclusion, et cetera, you didn't mention whether these reforms were in regard to any policy in that market, or whether to contain costs you are talking about a basic plan.

Are these reforms independent of the issue of type of plan and of overriding State mandates? What are the cost implications of either alternative?

Mr. TRESNOWSKI. You are talking about a basic benefit plan, a definition of what a basic benefit plan—

Mrs. JOHNSON. Well, are HIAA and Blue Cross and Blue Shield in support of reforms like guaranteed availability and no exclusion of preexisting conditions and so on? Do you support those reforms for the market as it is now? Do you support those reforms for a basic plan in addition? What would be the cost difference between those two options?

Mr. CURTIS. All of the market reforms we have described would pertain to all medical benefits offered to small employers, with the exception of guaranteed availability.

With respect to guaranteed availability when people first apply for coverage, we are talking about several prototype plans being made available: one a basic benefit plan that is more affordable than now available in most States because of mandated benefits. That package would be reinsured. Also, a more mainstream benefit package, and that package would be reinsured. And, in addition, a managed care benefit package that, for example, for federally qualified HMO's would comport with Federal law as to what HMO's have to cover. That, too, would be reinsured.

We are tying that, again, to reinsurance. For a variety of reasons, having the reinsurer reinsure a whole broad range of benefit packages is not only very inefficient and complex administratively, it would undoubtedly lead to inequities in terms of cross-subsidies among competitors.

On the other hand, reinsurance would be available for persons covered by broader benefit packages. It is just that the insurer who obtained it would only have covered those expenses associated with a prototype benefit plan.

Mrs. JOHNSON. Since price is clearly the driving force of the other problems, have you been able to analyze what the difference in cost would be for a prototype core benefits plan under these conditions versus an HMO managed care approach versus other things? Do you have any rough estimates as to how much that would bring—

Mr. CURTIS. Well, the basic benefit package should bring the cost down vis-a-vis what is now available on the market by approximately 15 percent or so. Again, in the case of the health maintenance organization, there is a set of requirements as to what has to be covered under Federal law. We are not asking for an exemption from that. So it would not have that price effect. It would, though, make it possible for them to offer coverage to any high-risk employer group. We strongly support, as you well know, managed care systems, and it is very important that these highest risk people who incur the highest costs have the most efficient financing and delivery systems available to them. We should encourage that, not discourage it.

Mr. TRESNOWSKI. Mrs. Johnson, if I may, it is hard to compare because you would have to define the benefit under one and define the other one. But I think Mr. Sutton in his prepared testimony pointed out that the elimination of State mandates had the effect of a 25-percent differential over a defined traditional benefit product.

Our own experience in places like Virginia and the State of Washington and in the State of Illinois show that it is in the range of 15 to 20 percent differential.

Mrs. JOHNSON. Could you discuss a little bit further the payer reforms that you are working on since administrative cost is something we are concerned about, and it is one of the things that appears to be quite different in other nations? How far have you gotten in uniform claims proposals? What implications do you think they have for administrative costs?

Mr. CURTIS. Again, our people, along with Blue Cross and Blue Shield plans and others, have been working on this for several years. There will be a final draft in early 1992. It will be pilot tested in 1992. It is hoped that all will go well, and it can go wide shortly thereafter, say in 1993.

Mrs. JOHNSON. Would it allow all insurers to use the same mechanism? Would it create a uniform payment format, and would it be computerized? Would it cut costs?

Mr. CURTIS. Yes. That is the idea. Now, I am not informed about the particulars of who will pay and what the schedules would be, what the attitudes of various organizations are about voluntary versus mandatory participation. I understand, for example, the American Medical Association is very reluctant to go along with the notion that all physicians would have to have a personal computer on site and be familiar with this. The software developers will try to design it so that it is very user friendly—very easy to use.

If physicians and hospitals were to use this approach, obviously there would be very substantial administrative savings for them vis-a-vis dealing with a whole variety now of claims forms and processes.

Mrs. JOHNSON. There is another aspect to administrative costs that we haven't discussed very much, and I just wondered if you are doing any research on it. One of the costs that I have been, unfortunately, all too familiar with, both as a State senator and gradually as an ombudsman for my constituents, is the costs associated with late payment, particularly for small providers who actually have to borrow that money at an interest cost to pay for services. The costs associated with late payments are a serious problem. Recently in the Medicare system, we have had a very great problem with delayed payment.

I wonder if you have done any analysis of the private sector's timeliness of payment versus the public sector's timeliness of payment, both in Medicaid and Medicare. I am well aware that over time there have been fluctuations. In terms of how the system is working now and in recent history, what do we see?

Mr. TRESNOWSKI. We in Blue Cross and Blue Shield have very accurate statistics going back 10 years on the turnaround time on claims. Our target is 14 days, which is very prompt payment. In addition to that, we have advances to both hospitals and doctors so that they aren't carrying any of that weight in terms of any potential delay.

That is not the standard under the Medicare program. In fact, I think the standard there is 24 days. But that is related largely to the administrative costs. If you want to reduce the administrative costs, you reduce the timing of how quickly you pay the claims.

Mrs. JOHNSON. Yes. But Medicare's standard and Medicare's practice are two different things, because their standard just requires that they respond. Recently they have been responding by saying we need more information, and then when you ask them what information, they say, oh, well, I guess actually we don't need more information. There is a lot of stuff going on out there that results in payments being delayed 2 and 3 months and sometimes more, when there really wasn't any dispute.

We need much better data than that. I think you do have good data. I don't know whether or not the rest of the industry has good data about timeliness of payments.

Mr. CURTIS. My department does not collect that. I believe HIAA has, for some period of time as well, collected data on promptness of payment. I know that on average private insurers are substantially more prompt than Medicare or Medicaid.

I might emphasize here that one of the ramifications of the low administrative costs Medicare and Medicaid enjoy is inadequate communications, shall we say, between hospitals, doctors, and your fiscal intermediaries. I just heard a presentation by the Medicaid director in Pennsylvania. Basically they are down to bare bones now. And when their system rejects a bill coming in, it just goes back to the provider with no indication at all as to what the problem is because they don't have the staff to handle it. It just says "error." That, of course, creates substantial problems in the system. To be able to handle that kind of thing requires communication, and communication does cost some money.

Mrs. JOHNSON. I think that a problem we often run into in Government is that inability to manage that kind of kickback controversy.

Mr. WALWORTH. If I can just comment on that same issue, here, again, I think it is a prime area in which the differences between many HMO's and the claims-driven insurance system begins to have an impact. Most of us have a large amount of health care services that are provided in a non-claims-paying mode. So we are not waiting for a piece of paper or even a blip on the screen to come across to tell us there is a service that needs to be reimbursed.

Mrs. JOHNSON. So your administrative costs, since they are simply capitated, are very low because they are not—

Mr. WALWORTH. They are remarkably lower in terms of the claim processing part. That is correct.

Mr. MOODY. What are they? What percentage of costs go to administrative in HMO's?

Mr. WALWORTH. Across the HMO's, I really don't know the answer. I am sure we have it and GHAA can provide it. In my own organization, our total nonhealth care expenses are 6 percent of total premium.

Mr. MOODY. Six percent. Well, I think it is known that the average administrative overhead costs for the American health care system in its totality is about 12 percent.

Mr. WALWORTH. That is right.

Mr. MOODY. That includes HMO's, that includes Medicare, which is about 2 percent. So the non-Medicare, non-HMO is obviously considerably higher than 12 percent.

Mrs. JOHNSON. If the gentleman will yield?

Mr. MOODY. Sure.

Mrs. JOHNSON. The 2 percent in Medicare does not include the buildings in which the people work, or the capital investment of that nature associated with administrative costs. So they are not comparable figures. Unfortunately, the Medicare administrative costs do vary this issue of the burden imposed by nontimely response.

Mr. MOODY. If the gentlelady would yield back, if we put the capital costs into Medicare—you say it is not included. If we put the capital costs back in, then the overhead would shrink below 2 percent.

Mrs. JOHNSON. No, no, it would go up because there is no allocation, no recognition.

Mr. MOODY. That is not what I am talking about. I am not talking about capital costs. I am talking about administrative costs as a percentage of total cost, not brick and mortar. If you add brick and mortar into the base and you have the same numerator in the ratio, then the ratio will go down, not up.

Mrs. JOHNSON. My belief is—and certainly the panel can comment on this—that when you talk about administrative costs, you are talking about a percentage of costs that include the cost of all your buildings and equipment, land, everything. When we talk about administrative costs, we are not including the costs of buildings, equipment, and land.

Mr. MOODY. Yes; but that is in the base. I am talking about the numerator. You have got a ratio here of administrative costs to total costs, including everything.

Mrs. JOHNSON. But you have to allocate to the administrative cost factor a percentage of your investment in land, equipment, and so on, not just the salaries of the people. Anyway, that is something we can look at in more detail later.

Mr. MOODY. Mr. Curtis, a moment ago you lumped Medicaid and Medicare together in your comments about the billing and the turnaround and so forth. My understanding is that they are very, very different for obvious reasons. Do you want to reconsider that comment, or is that a slip of the tongue?

Mr. CURTIS. What I was saying is that in both cases administrative cost figures are low, and they are low relative to ours. However, Representative Johnson is correct. One of the reasons is the Government does not include in its calculation costs that are included in our case. And with respect to commercially insured cases, there are, we estimate, approximately 4 percent in taxes of various kinds that are built into our administrative cost as shown in national spending accounts.

My point was simply this; that if you talk to providers, I think you will find that they will say if they have a problem, if they have a misunderstanding with a billing problem with Medicare or Medicaid—and the problem is usually far more severe with Medicaid—

Mr. MOODY. Right, that is my point. There are very big differences.

Mr. CURTIS. It is more severe in Medicaid. On the other hand, I think you will find they will uniformly say that in these Government programs there is oftentimes no “there” that exists in terms of someone to talk to about whatever the billing problem is and to be guided as to how the bill can be corrected so it can be paid.

Mr. MOODY. Over the last several years, there has been a conscious policy of reducing the deficit by stringing out Medicare payments and the part payment solution, so-called. This has been an engineered problem as a result of straining to reduce the deficit without raising taxes or making other painful steps. So you are

quite right about it. But I just wanted to distinguish Medicaid from Medicare. My understanding is they are quite different.

Any final comment?

Mr. TRESNOWSKI. Mr. Moody, I was just interested in the colloquy between yourself and Mrs. Johnson. It illustrates on the administrative cost issue that you get into apples and oranges discussions on this. Let me underscore a point. The concern about administrative cost today is not processing of paper. In Blue Cross and Blue Shield, over 90 percent of the hospital claims are electronic. There is no paper involved at all. The rise in administrative costs in recent years—incidentally, ours was as low as 6 percent; we are now up to 9 percent. The rise is associated with the cost in managing the care. You hire rooms full of nurses, doctors and others to evaluate claims, to evaluate the patterns of patient care, and the interaction that goes on between our staffs and the doctors and the hospital. That is what builds the administrative cost.

Mr. MOODY. On the hospital side. But on the physician side, there is still a lot of paper.

Mr. TRESNOWSKI. Managing care builds the cost on both sides.

Mr. MOODY. I am sorry, but, I mean, my only response to your electronic answer is that when I went into my doctor's office the other day, I was amazed how many people are pushing paper in there. There is still a lot of paperwork in physicians' offices, if not in hospitals.

Mr. TRESNOWSKI. That may well be, but in our case, even on the physician side, we are up to 60 percent electronic claim processing. But, you know, there are a lot of insurance carriers out there.

Mr. MOODY. Right, with different forms. But your point, I think, sounds very reasonable that the second—what do you call that whole industry?

Mr. TRESNOWSKI. Managed care.

Mr. MOODY. Managed care, that whole review process generates a lot of administrative cost.

Mr. TRESNOWSKI. But it generates administrative costs. But the data is very clear, and we can provide it to the committee, that those investments in administration pay back substantially, multifold, in reduction in health care expenditures.

Mrs. JOHNSON. Could I ask the gentleman to provide us with that information? I think we need to have a better understanding of the relationship between administrative costs and cost control. The part of your costs that are going up, I understand you to say, is associated with managed care, not with actual billing. The implications of that is that this uniform payer system, while it might save us some money, is not going to save the big bucks. Behind the payer system has to be a managed care system, and the question is: Can you do the managed care role in a more cost-effective manner than we can do the managed care role? That is what a lot is going to turn on.

I wonder what you think about that. Why do you think you might do it more efficiently?

Mr. TRESNOWSKI. Oh, absolutely. I just firmly believe that a private carrier using the variation that exists, the opportunity to negotiate, to contract, has a greater opportunity to control the health care costs at that level.

One of the problems of a uniform single payer arrangement is it will sanctify the system. Everybody will stay in place. It will eventually become politicized, and they will not be able to make the kinds of decisions that are made at the community level.

Mr. Moody. OK. Thank you very much. We appreciate your being here. The testimony was very helpful.

[Whereupon, at 11:25 a.m., the subcommittee was adjourned.]

1. The first part of the paper is devoted to a general discussion of the problem of the existence of solutions of the system of equations (1) for arbitrary values of the parameters α and β . It is shown that the system has solutions for arbitrary values of the parameters α and β if and only if the condition $\alpha + \beta = 1$ is satisfied.

2. In the second part of the paper the problem of the existence of solutions of the system of equations (1) for arbitrary values of the parameters α and β is solved. It is shown that the system has solutions for arbitrary values of the parameters α and β if and only if the condition $\alpha + \beta = 1$ is satisfied.

3. In the third part of the paper the problem of the existence of solutions of the system of equations (1) for arbitrary values of the parameters α and β is solved. It is shown that the system has solutions for arbitrary values of the parameters α and β if and only if the condition $\alpha + \beta = 1$ is satisfied.

4. In the fourth part of the paper the problem of the existence of solutions of the system of equations (1) for arbitrary values of the parameters α and β is solved. It is shown that the system has solutions for arbitrary values of the parameters α and β if and only if the condition $\alpha + \beta = 1$ is satisfied.

5. In the fifth part of the paper the problem of the existence of solutions of the system of equations (1) for arbitrary values of the parameters α and β is solved. It is shown that the system has solutions for arbitrary values of the parameters α and β if and only if the condition $\alpha + \beta = 1$ is satisfied.

6. In the sixth part of the paper the problem of the existence of solutions of the system of equations (1) for arbitrary values of the parameters α and β is solved. It is shown that the system has solutions for arbitrary values of the parameters α and β if and only if the condition $\alpha + \beta = 1$ is satisfied.

7. In the seventh part of the paper the problem of the existence of solutions of the system of equations (1) for arbitrary values of the parameters α and β is solved. It is shown that the system has solutions for arbitrary values of the parameters α and β if and only if the condition $\alpha + \beta = 1$ is satisfied.

8. In the eighth part of the paper the problem of the existence of solutions of the system of equations (1) for arbitrary values of the parameters α and β is solved. It is shown that the system has solutions for arbitrary values of the parameters α and β if and only if the condition $\alpha + \beta = 1$ is satisfied.

9. In the ninth part of the paper the problem of the existence of solutions of the system of equations (1) for arbitrary values of the parameters α and β is solved. It is shown that the system has solutions for arbitrary values of the parameters α and β if and only if the condition $\alpha + \beta = 1$ is satisfied.

HEALTH INSURANCE OPTIONS: REFORM OF PRIVATE HEALTH INSURANCE

THURSDAY, MAY 23, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:15 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

Chairman STARK. The Subcommittee on Health of the Committee on Ways and Means will continue hearings on health insurance options and discuss today changes in the private health insurance system.

Thirty-four million Americans do not have basic health protection, and there is a rising level of interest in the problems of the private health insurance system.

I am doubtful that private insurance can ever be the total answer to the problems we face in the health care system. This skepticism has increased particularly in recent days given the response of representatives from some of the health insurance plans in my own State of California to the introduction of the health insurance reform bill, H.R. 2121.

When asked about that bill, a spokesman for the California Life Insurance Co. told reporters that the health insurance members of his association didn't want to have anything to do with insuring the sick, because "everyone else would have to pay for them."

That is precisely the problem with private health insurance—a "use it and lose it" kind of mentality which spends all its time identifying how to exclude anyone who might incur health care costs, and unfortunately not enough time is spent aggressively managing the increasing costs of health care.

The wide use of experience rating of premiums, as opposed to community rating, increases prices to many businesses. Other underwriting practices which increase the difficulties of companies in purchasing insurance include exclusions for preexisting conditions, and the segregation of workers with high risks and excluding them from group rates.

Our goal in these discussions is to assure that no American lacks basic health insurance coverage. Reform of private health insurance may be a reasonable first step to take toward that goal.

To that end, I look forward to hearing from our expert witnesses on the problems of health insurance and about suggestions as to how these problems might be solved.

[The opening statement of Chairman Stark follows:]

OPENING STATEMENT
 THE HONORABLE PETE STARK
 CHAIRMAN, SUBCOMMITTEE ON HEALTH,
 COMMITTEE ON WAYS AND MEANS

HEARING ON HEALTH INSURANCE OPTIONS:
 REFORM OF PRIVATE HEALTH INSURANCE

May 23, 1991

Today the Subcommittee continues its series of hearings on health insurance options with a discussion of reform of private health insurance.

Given that almost thirty-four million of our fellow citizens must do without the basic protection of health coverage, the rising level of interest in the problems of the private health insurance system is not surprising.

I am increasingly doubtful that private insurance can ever be the answer to the problems we face in the health care system. My skepticism has increased particularly in recent days given the response of representatives of some health insurance plans in my own State of California to the introduction of my health insurance reform bill, H.R. 2121.

When asked about my bill, a spokesman for the California Life Insurance Companies told reporters that the health insurance members of his association didn't want to have anything to do with insuring the sick, because "everyone else would have to pay for them."

That's precisely the problem with private health insurance -- a use it and lose it kind of mentality which spends all its time identifying how to exclude anyone who might incur health care costs, and not enough time aggressively managing skyrocketing health care costs.

I believe the time is long overdue to enact comprehensive reform of the health care financing system -- and to enact it soon. I have introduced H.R. 650, the MediPlan Act of 1991. H.R. 650 would provide every American with comprehensive, cost-effective health coverage based on the Medicare program.

I have introduced MediPlan because I do not believe piecemeal approaches based in the private sector will achieve our common goal of universal coverage. I also believe strongly that only a universal approach in the public sector can achieve containment of skyrocketing health care costs.

While pursuing long-range reform, I believe it important that we also explore other, short-term, approaches which may help alleviate some of the problem. One such area is reform of private health insurance.

Various practices of the health insurance industry appear to increase the problems faced by companies in purchasing health insurance.

The wide use of experience rating of premiums, as opposed to community rating, increases prices to many businesses. Other underwriting practices which increase the difficulties of companies in purchasing insurance include exclusions for pre-existing conditions, and segregation of workers with high risks from group rates.

Our goal in all of these discussions is to assure that no American lacks basic health insurance coverage. Reform of private health insurance may be a reasonable first step to take towards that goal.

To that end, I look forward to hearing from our expert witnesses on the problems of health insurance, and about their suggestions as to how those problems might be resolved.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman. I am delighted that you scheduled this hearing and that we have so many excellent witnesses who are going to appear before us today. I want to apologize to them and to you in advance for the fact that I have to be at a Budget Committee hearing with Chairman Panetta at 11 o'clock.

I do want to say with regard to the basic issue before us that I don't think the answer to this problem is to throw out the system we have and substitute a Government insurance program for it; but, rather, to make the system with all of its problems that we now have in the private sector today work better.

I am not overwhelmed with the performance of the Federal Government in the health care field. The two areas in which we have had total responsibility for a long time, which are the Veterans' Administration health care programs and the Indian health care programs, are not programs which, in my mind, would give me very great confidence that those should be extended to the populace as a whole. And the programs which affect so many people and involve both Federal and State activity, Medicaid and Medicare, have become part of the problem rather than part of the solution by becoming such chintzy reimbursers for services.

Maybe because I wear this budget hat as the ranking member of the Budget Committee, in any event because of my observations of our budget-driven policies over the years and my anticipation that this concern about the budget will overwhelm any concern about the development of sound health policy, I think the focus on how to make the present health insurance system in the country work better is most likely to yield results.

So, again, I congratulate you for focusing attention on this issue and giving us a chance to hear from the witnesses.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. Thank you, Mr. Chairman.

First I would like to ask unanimous consent to submit for the record a written statement.

Chairman STARK. Without objection.

[The statement of Mr. Chandler follows:]

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Statement of the Honorable Rod Chandler
on the introduction of the
Small Employer Health Insurance Incentive Act of 1991

Mr. Speaker, there is a growing consensus among the members of Congress that the United States is in the midst of a crisis; that crisis being inadequate health coverage for American citizens. And as that consensus grows, the members of Congress, as well as the American public, become increasingly familiar with the statistics associated with that crisis -- 34 million Americans with no health insurance and health care costs which now exceed 11 percent of our Gross National Product (GNP)

Those statistics have appropriately generated much concern, to which Congress has responded with any number of proposals to cure the country's health care ills. Many of these proposals would dismantle our entire health care system and replace it with a national, single payor system.

Unfortunately, most of these proposals ignore the fact that our current system of employer-provided health insurance has been very effective. Their proponents would dismiss the fact that most Americans who have health insurance, obtain it through their employers. I submit that instead of tossing aside a system with proven success, Congress should be taking steps to expand that system to those working Americans who are currently unable to gain access to it; most notably, employees of smaller businesses.

Mr. Speaker, it is with that goal in mind that I am pleased to introduce today, along with a number of my colleagues, the Small Employer Health Insurance Act of 1991.

Under our current health insurance system, it is exceedingly difficult for smaller employers to obtain an adequate level of group health insurance at a reasonable cost. This fact is borne out in another of those telling statistics -- of the 34 million Americans without health insurance, more than 18 million work in small businesses or are dependents of workers in small businesses. Due largely to economies of scale, small employers have limited access, if even that, to affordable group health products.

- more -

By contrast, large employers enjoy the economic means to self-insure under the Employee Retirement Income Security Act (ERISA) and, as such, are exempt from state regulation of health insurance. Those large employers who may elect not to self-insure still enjoy, by virtue of their size, the ability to negotiate aggressively on behalf of their employees to secure the lowest health insurance rates available.

The simple idea behind the Small Employer Health Insurance Incentive Act is to enable small employers, including the self-employed, to become part of a large employer group for the purpose of purchasing health insurance.

The model for the bill is the Council of Smaller Enterprises (COSE) in Cleveland, Ohio. COSE is a employer purchasing group that makes affordable health insurance available to its 10,000 member employers. This translates into health coverage for more than 120,000 workers and their dependents; 120,000 Americans who, if not for the leverage provided by COSE's size, would have no health insurance of any kind.

To encourage the formation of employer purchasing groups, similar to that of the COSE group, the bill would eliminate various factors that contribute to the high cost of health insurance. Specifically, the bill would exempt these groups from state-mandated health benefits, state taxes on health insurance premiums and state restrictions on managed care activities.

Each of the state-imposed mandates addressed by bill have been shown to contribute to the high cost of health care, particularly for smaller employers. For instance, state governments across the country have mandated over 800 different health benefits. A study by the National Center for Policy Analysis estimates that as much as 25 percent of the uninsured lack health insurance because of state-mandated benefits.

Similarly, state insurance premium taxes can run as high as 4 percent of premiums. These costs are immediately passed on to employers in the form of higher premiums.

Finally, managed care activities, such as utilization review and selective contracting, have been shown to be an effective means of controlling health care costs. And yet, many states impose restrictions on these activities, greatly diminishing their effectiveness.

Our bill seeks to help small employers overcome some of the obstacles to obtaining affordable health insurance, but it does so in a prudent and responsible fashion. For instance, the bill establishes specific requirements that a group must meet in order to qualify as a purchasing group. Furthermore, employer purchasing groups must be certified by the Secretary of the Department of Health and Human Services before they can purchase health insurance; and such insurance must be purchased from a licensed insurance carrier.

Mr. Speaker, the Small Employer Health Insurance Incentive Act is not the answer to all of our health care problems. Clearly, much more needs to be done. But this bill represents another important step that Congress can take now to address those problems in a meaningful way; and do so within the context of our current health care system.

I urge my colleagues to join me in this effort to address our country's health care crisis.

Mr. CHANDLER. Because we have the fast track legislation on the floor today, I know that I am going to have to go over there at some point and participate in that debate.

Chairman STARK. I trust you are going to vote against it, and then I will give you an excuse. [Laughter.]

Mr. CHANDLER. Darn, we will cancel each other, I guess.

I would certainly like to endorse the statement you made that reform of the private health insurance market is perhaps a reasonable first step. I introduced today, along with my colleagues, Mrs. Johnson, Mr. Gradison, and others, legislation that would, I think, go a long way in taking that very reasonable first step toward insuring Americans who do not currently have insurance by reducing the cost of insurance for employers who do now pay for insurance.

Essentially, it would exempt from State-mandated benefits a group that is formed of 100 or more employers. Only employers with 100 employees or fewer may join. It is based on the model developed in Cleveland called COSE, Council of Small Enterprises. You will hear more about that from John Polk in a bit.

We would exempt these groups of small businesses formed for the purpose of purchasing health insurance from State-mandated benefits, State insurance premium taxes, and State restrictions on managed care. My strong belief is that we could do that immediately and have immediate impact on the health insurance market. But, we will save that for those who are here to testify, and I thank you, Mr. Chairman.

Chairman STARK. Thank you.

Mrs. Johnson, did you want to make a statement?

Mrs. JOHNSON. Thank you, Mr. Chairman. I will be very brief because we all are involved in the action on the floor. If you take the vote according to this panel, I am pleased to say fast track will pass. [Laughter.]

I do think that it is extremely important, and I appreciate, Mr. Chairman, you holding this hearing. This is extremely important that Congress recognize two things. One of them is that we are part of the problem. We have put in place incentives. We have allowed laws to develop that increase costs. Spiraling health care costs is the sole cause of our problems, and there are a lot of reasons why costs are spiraling. It is the unaffordability of health care that has diminished access, both to Government programs and to private sector programs. It is fundamentally cost control that we have to address if we are going to solve the health care problem.

My preference is to do that in a way that takes advantage of the extraordinary energy and creativity of the private sector, and particularly the small business entrepreneurial private sector. I am pleased today that this panel will bring to us a lot of experience and thought from that sector because, without their ideas, I don't think we can come to good solutions. Without their ideas we could make further mistakes. Some of the things, as our bill demonstrates, that have to be done require the Congress to recognize that in the past we have done some things that are now unhealthy, even though we did them for the very best reasons, and at the time they might even have been very good policy.

But we have to be able to reevaluate the role of Government and to look at it as one of the cost drivers. I welcome you all here this morning and look forward to your testimony.

Thank you, Mr. Chairman.

Chairman STARK. Would the gentlelady yield?

Mrs. JOHNSON. I would be happy to.

Chairman STARK. I am confused. Was the gentlelady suggesting we repeal Medicare?

Mrs. JOHNSON. No, absolutely not. I am not suggesting that. I am suggesting—

Chairman STARK. You don't think that is a mistake, then?

Mrs. JOHNSON. No; but I am certainly suggesting that we, for instance, reverse our policy in regard to the self-employed so we treat them with the same equity as other—

Chairman STARK. OK. I just wanted to make sure. This committee has jurisdiction over Medicare, which I am quite proud of, and I have heard the Republicans suggest this morning that this is a problem. I would assume that the Republican Party supports Medicare as a benefit for the seniors, does it not?

Mrs. JOHNSON. Of course we do, Mr. Chairman.

Chairman STARK. Yes. OK. Well, I just want to keep the record straight here that the whole Government isn't the fault.

Our first witnesses comprise a panel. The Robert Wood Johnson Foundation, who so generously does wonderful work in the field of research and in funding fellowships, many of which go to enlighten Members of Congress, is represented by Nancy Barrand, the senior program officer of the foundation, and by Dr. David Helms, the national program director of Health Care for the Uninsured Program. They are accompanied by Judith Glazner, the project director of SCOPE, and Ree Sailors, project director of the Florida Health Access Corp.

We also have the Council of Smaller Enterprises represented by John J. Polk, the executive director.

I would suggest to all of you that your written statements will become a part of our record without objection, and we would ask you if you could summarize your testimony or expand on it in any way that you are comfortable.

Ms. Barrand, would you like to lead off?

STATEMENT OF NANCY L. BARRAND, SENIOR PROGRAM OFFICER, ROBERT WOOD JOHNSON FOUNDATION, PRINCETON, NJ, ACCOMPANIED BY W. DAVID HELMS, PH.D., NATIONAL PROGRAM DIRECTOR, HEALTH CARE FOR THE UNINSURED PROGRAM, ROBERT WOOD JOHNSON FOUNDATION, AND PRESIDENT, THE ALPHA CENTER; JUDITH GLAZNER, SCOPE PROJECT DIRECTOR, DENVER, CO; AND REE SAILORS, EXECUTIVE DIRECTOR, FLORIDA HEALTH ACCESS CORP., TALLAHASSEE, FL

Ms. BARRAND. Mr. Chairman, Members of the committee, thank you for inviting us to testify today on ways to expand coverage to the uninsured. My name is Nancy Barrand. I am a senior program officer with the Robert Wood Johnson Foundation, a private philanthropy in the health care field. I have primary responsibility for

the foundation's Health Care for the Uninsured Program which we are going to discuss today.

Before I take up that task, let me introduce Dr. David Helms, our national program director for the foundation's Health Care for the Uninsured Program, and president of the Alpha Center. Also with me here today are two of our star project directors: Ree Sailors with the Florida Health Access Corp., funded under a grant to the State of Florida; and Judy Glazner with the SCOPE Program in Colorado, developed under a foundation grant to the Denver Department of Health and Hospitals.

Very briefly, in 1986 the foundation made \$6 million available to 15 sites to develop and implement new public and private financing and service delivery arrangements that would improve access to care for the uninsured. While no single model was prescribed, each of these projects focused on ways to increase coverage to the working uninsured. Overall, this program has shown that if we are to continue to rely on the existing private, voluntary, employer-based health insurance system, it is critical that we fix the problems of affordability and availability in the small group insurance market.

Our program demonstrates the value and limits of using public/private partnerships to leverage more private dollars into the insurance system to cover the uninsured. And, finally, it illustrates how Government can use subsidies creatively and efficiently to expand coverage.

While we are not here today to suggest that we have found a solution, I think, as you will hear from Dr. Helms, the program has helped to identify some of the issues that will need to be addressed should we pursue either a voluntary or a mandatory approach to expanding coverage in the small group market.

Mr. HELMS. Thank you, Mr. Chairman, and Members of the committee. My name is David Helms. I am going to use these handouts that accompanied our testimony.

As you can see from the first handout, our——

Chairman STARK. David, which? This one?

Mr. HELMS. Yes. Our surveys from different parts of the country confirm that the cost of health insurance is the major factor. While the problems firms and individuals have in obtaining health insurance are serious problems and need to be addressed, I want you to make sure that you understand that the overwhelming problem is the cost of this health insurance and that what you do not contribute to the cost of this insurance.

The second slide shows something you have probably seen, the CRS and others have reproduced——

Chairman STARK. Can you put into a range here what we are talking about? Are we talking about \$1,000 a month, \$100 a month, \$500? It would——

Mr. HELMS. I am going to show you the premiums in just a few minutes that we are doing and how much below they are the market price. So I am honestly going to get there.

Chairman STARK. All right.

Mr. HELMS. The next slide talks about the administrative expenses for different size firms. And I call your attention to that so that you understand what while we can through the use of pools and community rating reduce the amount in that bottom cell for

risk and profit by pooling people, we will still have considerably higher costs to try to sell insurance and to administer plans for the small group market. Our projects would confirm that it costs more money to market and to administer projects for the small groups. Pooling helps, but it is only that part that relates to the risk factor.

The next slide shows you the strategies that we have been testing to make health insurance more affordable. This may sound simple to you now. It took us a while to figure this out. There are only two ways to make health insurance more affordable. You either offer less, or you subsidize it. The ways you can offer less are limit the benefits, but I am here to tell you that that is not a very popular market solution. The small employers that we have surveyed want basic health insurance. They want hospital coverage. They want catastrophic protection. And they want primary care services.

You can impose major cost sharing, and as I hope you will get a chance in questions to hear from Judy Glazner, this is a very exciting and innovative package that uses very good primary care, preventive care, and poses significant cost sharing in the middle and has very good catastrophic protection. I think that is an innovation in insurance that may make a contribution.

I also think I can report that these projects are willing to accept significant channeling into a very limited provider network. They will go where we tell them to go if it is good coverage.

On the subsidy side, that is easy. You can make health insurance more affordable by subsidizing it. But the basic point I think that these projects have shown is that Government can do a lot through indirect subsidies, by taking on the administrative function, by taking on some of this marketing, by taking on some of this claims administration. And since this country has chosen to use an employer-based system and since there is no equitable reason for small employers and individuals to have to pay 30 or 40 percent more for the cost of health insurance, then I think Government has to level the playing field between the small employers and the large employers. And a way to do that is for Government to take on some of these administrative and marketing and pooling responsibilities.

You asked about the premiums. Let's go to the chart that shows you the monthly premiums. You will see that our projects had premiums, monthly premiums—and we are showing you now single and family coverage—that are significantly below national HMO averages. They range in the amount of discount from prevailing rates by 30 to 50 percent. And that is the good news. These creative arrangements are able to bring the price of insurance down. But as you will see from our enrollment date, we haven't had significant market penetration, and I will talk about that. This is still a tough thing to get done even when you lower the price of insurance.

The next slide I have for you was on making health insurance more available, and so much attention has been focused this last year on reforming small group market practices, and I don't want to get in the way of that. But even on making health insurance more available, I want you to understand there are other things that need to be done, like creating more stable pools. Government could do a lot to help stabilize these pools by providing this reinsur-

ance mechanism, by setting up buying cooperatives like Ree Sailors has done in Florida.

But you also have to do some aggressive marketing and advertising if you want to get the word out to these small employers. They don't understand insurance. They don't understand indemnity, HMO, cost sharing. This is a very complicated mess. There are hundreds of companies in this business competing, and they get frustrated understanding it.

Again, the enrollment data, it is modest, but you need to understand that we went after the hardest to reach market. We went after the very small firms, the micro firms. The average firm size is 2.9. The average group size is 5.2. We went after the previously uninsured firms. Many of our projects said you can't get access to these subsidized products if you have health insurance. We didn't want to create that inequity.

So we went after the hard part of this market to serve, and many of these projects kept the subsidy dollars. And my finding about the subsidies really are that the Federal Government, I think, could go a long way to leverage the State governments doing more here and to stabilize these subsidy dollars.

So if I could summarize my key lessons, and I have provided you with written testimony that takes you all the way through all the lessons we think we have learned from this effort, you have to address both affordability and availability. You have to develop direct premium subsidies to help those low-income persons afford health insurance. Those between 100 and 200 percent of poverty are going to have a very hard time. A mother of two children, a three-member family making \$12,000 or \$13,000 a year can't spend \$3,000 to \$4,000 a year on health insurance. It just isn't going to compute.

Indirect subsidies, I really stress, as a very important way for us to address this problem. States can create buying cooperatives. They can take on some pooling. They can help purchase reinsurance. They can help get the word out to small employers. They can set up information and referral services. That helps reduce the cost overall for this small group market. And even with premiums of 25 to 50 percent below the market rates, I have to tell you honestly that we can't tell you that we can penetrate more than about 20 percent of this market.

We are trying very hard. We have worked very hard at doing it. Government could help make these subsidies more permanent, and it could help these employers know that this is for real. A lot of these employers are sitting on the sidelines saying to us, We don't know how long your demonstration is going to be there. So we need to stabilize this market as we also reform the market.

[The prepared statement follows:]

TESTIMONY BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

Nancy L. Barrand, Senior Program Officer
The Robert Wood Johnson Foundation, Princeton, New Jersey

W. David Helms, Ph.D., National Program Director
Health Care for the Uninsured Program
The Robert Wood Johnson Foundation
and
President, Alpha Center
Washington, D.C.

May 23, 1991

BACKGROUND

In 1986 The Robert Wood Johnson Foundation initiated the Health Care for the Uninsured Program. This program was developed in response to the growing number of uninsured Americans experiencing difficulty obtaining health care, and the increasingly serious financial burden placed on the institutions that continued to serve them. There was also compelling evidence that as a group, the uninsured have more health problems, yet get less health care than the insured.¹

Health care for the uninsured had traditionally been financed by a combination of direct government payments and cross-subsidies from private insurance. However, as a result of intensified efforts by government and the private sector, financing from both sources had been eroding. In the 1980s, the federal government sought to control soaring health care costs by implementing Medicare's Prospective Payment System and fostering increased competition in health care markets. Private businesses, especially large firms, had also sought to cut health care premiums for employees by self-insuring and taking advantage of the experience-rated products developed by the insurance industry. While the burden of providing inpatient care to the uninsured falls disproportionately on a relatively small number of hospitals, these institutions--already beset by cost-containment and market pressures--were encountering rising levels of bad debt and were unable to increase their uncompensated care loads sufficiently to meet the growing demand. Although many localities had arrangements for providing and financing care to those without insurance, there was substantial evidence that many Americans continued to "fall through the cracks."

In the mid-1980s, many states were studying the problems of access and the uninsured and were drafting legislation to expand financing and care for medically indigent and uninsured. However, state and local governments lacked resources for new program development and for the demonstration of new initiatives and they urged the Foundation to provide financial support for further analysis and development of their proposals.

Through the Health Care for the Uninsured Program, the Foundation sought to support the development and implementation of new public and private financing and service delivery arrangements in states and large urban areas. This Program was co-sponsored by the National Governors' Association, the National Conference of State Legislatures, the U.S. Conference of Mayors, and the National Association of Counties. The Foundation's National Advisory Committee included representatives from federal, state and local government, the insurance industry, health care providers, and the health policy and research community.

A total of \$6.16 million was made available over a five year period to support 15 projects. Seven grants were made to states, one to a city/county health department and seven to private organizations. These projects did propose varied strategies, as intended, but for the most part they were targeted at one specific population group -- the working uninsured and their families. The projects' focus was in response to research findings that about three-quarters of the uninsured population are workers or are dependents of workers and that two-thirds of uninsured employees work for small companies and about one-half for very small firms. This focus also reflected this country's reliance on the current employer-based system for providing health insurance coverage and the preference for using an incremental approach for addressing the gaps in access.

¹The Robert Wood Johnson Foundation. Updated Report on Access to Health Care for the American People, Special Report, No. 1, Princeton, NJ, 1983, p.6.

OVERVIEW OF KEY STRATEGIES

The projects developed a variety of mechanisms to reduce the cost of insurance for the small business market as they designed new products or modified existing products. Table 1 lists these strategies and shows how they were combined by various projects. Attachment 1, *Meeting the Health Insurance Needs of Uninsured Small Businesses: Market Research and New Products*, provides detailed information on the market research findings of the projects, describes the key features of the products, and analyzes their benefit plans.

Projects	Insurance Plan Innovations			Subsidy			Link to High Risk Pool
	Limited Benefits Options	Major Cost Sharing	Very Exclusive Provider Network	Direct Premium	Indirect: Pooling, Admin., Reinsur.	Discounts From Providers	
Central Alabama Coalition: BasicCare	■		■			■	
*Arizona: Health Care Group	■				■	■	
Colorado: SCOPE		■				■	
*Florida: HealthAccess Corp.				■	■	■	
*MaineCare				■	■	■	■
*Michigan: One-Third Share Plan				■		■	
Tennessee: MedTrust						■	
Utah Community Health Plan		■	■		■	■	
*Washington Basic Health Plan				■			
*Wisconsin: Maximization Project				■			■

* Indicates that project is sponsored by state government

Source: Alpha Center

KEY FINDINGS AND LESSONS

Overall this program has shown that if we are to rely on the existing employer-based system, it is critical to fix the problems of both affordability and availability in the small group health care market. It demonstrates the value and limits of using public-private partnerships which use limited public resources to create leverage for attracting more private dollars into the insurance system in order to cover previously uninsured persons. And finally, it illustrates how government can use its limited funds creatively and efficiently to increase health insurance coverage.

Although the projects have been in operation for only a few years, a number of key findings and lessons are already apparent, as described below. They are organized according to the following phases of program development: (1) market research, (2) developing strategies, (3) building public-private partnerships, (4) developing benefit plans and products, (5) marketing and (6) enrollment and utilization.

Market Research Findings

1. *Very small firms constitute a significant proportion of the uninsured.*
2. *Small employers do not now offer insurance primarily due to its high cost.*

The market research undertaken by the projects clearly indicates that cost is the major

obstacle for small firms. Many have thin profit margins and thus fewer resources to pay for premiums (See Table 2). Cash flow is tight and the uncertainty of both future income and expenses leads many new business owners to avoid the fixed-cost obligation of paying monthly insurance premiums. Those with seasonal business cycles experience wide fluctuations in revenues, expenses and employment levels. Also, many low-wage employees hired by these firms would not be able to contribute to the cost of coverage.

While not as significant as cost, a number of small firms also cited problems with the insurance market to explain why they do not offer insurance. Many said they were turned down because of size, their employees' pre-existing medical conditions, or type of industry. Some said they could not find an "acceptable" plan or lacked enough information to find and evaluate health plans.

TABLE 2
Reasons Reported by Small Employers
For Not Offering Health Insurance to Their Employees

Factors in Decision Not to Offer Insurance	Alabama (Birmingham)	San Diego	Denver	Maine (Brunswick)	Wisconsin (4 Counties)
<u>Cost:</u>					
Too Expensive	64.7	69.0	56.1	49.2	77.6
Firm Not Sufficiently Profitable	25.0	41.0	—	31.4	44.8
<u>Workforce Considerations:</u>					
Many Employees Insured Elsewhere	67.3	49.0	46.5	35.6	63.1
Employees Can Be Hired Without Providing Insurance	42.8	33.0	57.6	19.6	44.9
High Employee Turnover	19.0	22.0	23.2	13.6	19.0
Employees Don't Want It	39.1	25.0	16.0	12.7	43.9
<u>Insurance Market:</u>					
Company Turned Down:					
Too Small	25.0	22.0	19.2	10.3	*
Cannot Find an Acceptable Plan	22.8	32.0	24.5	14.7	31.5
Lack of Information/ Difficulty Judging Plans	17.9	19.0	16.9	16.0	31.6
Employees Cannot Qualify:					
Preexisting Conditions	11.3	10.0	8.6	7.9	24.1
Company Turned Down: Type of Business	11.4	7.0	2.9	*	*

*Survey did not ask this question.

3. *Most small businesses without health insurance have never offered insurance and know very little about it.*

Surveys showed that most small firms that did not have health insurance had never offered insurance to their employees. Only 9 percent of non-insuring small firms in San Francisco and 15 percent in Utah had ever offered coverage to their employees. In addition, only about one-third of small firms that do not offer insurance have recently considered doing so. Most non-insuring small employers surveyed had not investigated various health insurance options and do not have a regular source of information about health insurance.

4. *Small firms that do not offer insurance are concentrated in certain industries and employ higher proportions of female, low-wage and part-time workers.*

Survey data show that the percentage of small firms which provide health insurance to employees varies considerably across industries. Firms in the construction, retail trade, and service industries are the least likely to offer insurance, whereas manufacturing firms, mining firms, and wholesale trade firms tend to have higher rates of coverage. These differences in the coverage rates reflect variations in the nature of the work and the traditions of each industry.

Non-insuring small firms have a higher proportion of female employees than insuring small firms. The cost of health insurance coverage for women of child bearing age is often higher than the cost of insurance for men in the same age bracket, due to claims for obstetrics and maternity services.

Another characteristic of the employees of small firms is that many tend to be low wage-earners. Small employers hire a high proportion of low-wage workers, with non-insuring small firms hiring more than insuring small firms. In the Wisconsin survey of employers with fewer than 100 employees, approximately one-half of all workers earned \$3.35 - \$5.99 per hour, which at the time (1987) was just above the minimum wage.

The surveys showed that few small firms offer health insurance to part-time workers and that firms that do not offer health insurance to employees generally have a greater proportion of part-time workers.

5. *Even when small employers do offer health insurance, they often pay a very small percentage of the premium for dependent coverage.*

While there was considerable variability across the different market areas studied, a surprisingly high percentage of small employers in Tucson, Denver and San Francisco paid none of the dependent portion of the premium.

Lessons on Strategies

These projects show that the creative use of subsidies may provide significant leverage for extending employment-based coverage. Using a state subsidy, the Florida Health Access Corporation (FHAC) has attracted employer and employee payments that enable the state to achieve a matching rate which is superior to Medicaid, because 66 percent of premium dollars come from employers and employees. According to FHAC Executive Director, Ree Sailors, "FHAC is a mighty bang for the buck."

In general, projects with state subsidies had a broader range of strategies available to them than those sponsored by private non-profit organizations or local government. However, even projects without public funds were able to lower premiums and make insurance more available to their target market. Monthly premiums are shown below in Table 3.

Insurance Product	Single	Family 3 or More Persons	Approximate Discount Below Market Rates
Alabama: Private Option	73.96	186.32	30-50%
Public Option	45.07	110.86	
Arizona: Option Two	103.32	378.81	1%
Colorado: SCOPE	60.52	173.00	40-50%
Florida: High Option	96.46	264.61	25-40%
Standard Option	85.61	234.86	
MaineCare			
Unsubsidized (201% + FPL)	99.94	298.81	24%
Subsidized (101-125% FPL)	69.60	189.10	
Tennessee: MedTrust	65.84	177.75	50%
Utah Comm. Health Plan:			
High Option	64.45	190.64	40%
Low Option	58.25	172.71	
National HMO Average	133.40	354.28	

* Premium rates as of February 1, 1991

Sources: Alpha Center; GHAA

1. *To increase coverage in the small group market, it is necessary to make health insurance both more available and affordable.*

Some workers in small firms find insurance unavailable because their employers lack knowledge about possible products, and others are excluded from coverage because of their

medical history or type of industry. To increase availability, the projects have aggressively marketed their products and set up health insurance information and referral services for small employers and individuals. In order to attract insurance partners, they had to accept some of insurers' traditional exclusive underwriting practices.

The projects' research showed that it is not enough to simply make insurance available at any price. The central challenge is to make the product affordable for small firms, (who are more likely to have lower profits), and their employees, (who are more likely to have lower wages than their counterparts in large firms). The projects made insurance more affordable through innovative plans that either offered less benefits or imposed high cost sharing, or through direct and indirect subsidies.

While the strategies used by the projects help make insurance both more available and affordable, these isolated efforts were not able to overcome the more systemic problems within the small group insurance market. They underscore the need to create larger and more stable risk pools linked with reform of medical underwriting and premium rating practices.

2. *Government subsidies are needed to provide affordable coverage for low-income persons.*

Due to the lack of resources from either employers or employees, government subsidies are needed to provide affordable coverage for low-income workers and their families. As noted, a high proportion of small firms pay low wages to their workers. For these low-income families, the level of premium reduction that can be achieved through innovative benefit design and provider discounts is not low enough for them to afford voluntary coverage.

3. *Direct premium subsidies are effective at targeting low-income enrollees.*

Direct premium subsidies can be effectively targeted at individuals who are the least able to pay for coverage. Four projects offer direct premium subsidies to low-income persons based on a sliding scale of family income, and as a result the majority of their enrollees fall within the range of 100 to 200 percent of the federal poverty level. The Florida program uses state funds to "buy down" the cost of coverage for dependents, regardless of family income, because small employers contribute relatively little toward premiums for an employee's spouse and children.

Direct premium subsidies, however, have the disadvantage of being administratively complex. But perhaps the most important concern about direct premium subsidies is their vulnerability to changes in the state's political and economic climate. If a program relies on funds from the state to subsidize insurance premiums for low-income enrollees, these enrollees become vulnerable if the state subsequently decides to reduce or eliminate the subsidy.

4. *Indirect subsidies — administrative and marketing support, pooling, risk sharing and reinsurance, and provider discounts — lower costs for the entire small group market, but do not necessarily target low-income persons.*

The cost of administering and marketing health insurance is inherently higher for small groups than for large groups due to the nature of small businesses. In addition, insurers commonly set aside a larger percentage of premiums for "risk and profit," given their concerns about adverse risk selection. Rather than paying directly for a portion of the enrollee's premium, a number of projects are testing innovative ways of using public and private funds indirectly to lower the insurer's costs.

The appeal of subsidizing administrative and marketing activities and setting up pooling arrangements is that while they have high start-up costs and require a substantial investment during the initial developmental phase, they may then be maintained at a lower level. Some ongoing financial commitment is required, however, after the project becomes operational and enters the enrollment phase. Another advantage of this type of indirect subsidy is that either public or private resources can finance these services, as illustrated by the variations among the projects.

To reduce the perceived risk of covering a small group, several projects have implemented innovative methods of sharing risk, whereby another party — the state or participating providers — assumes a portion of the risk involved with covering enrollees. The Florida Health Access Corporation uses state funds to pay for that portion of the policy used to

protect its HMOs against hospital claims between \$15,000 and \$115,000. In this manner, the cost of protecting the HMO from this portion of risk is not passed on the consumer in the form of a higher premium. The State of Arizona does not contribute funds for reinsurance, but rather facilitates the purchase of reinsurance for the Health Care Group from the same reinsurer that underwrites its Medicaid Program.

Loss protection arrangements to shield the insurer from excess medical service expenses are also used to limit the insurer's risk. MaineCare reimburses (out of a risk reserve fund established by the state legislature) medical service expenses exceeding five percent of total premium obligations.

Providers can also assume a share of the risk. Under the Utah Community Health Plan (UCHP), participating hospitals cap the plan's catastrophic inpatient costs by providing free inpatient care after the thirtieth day of an enrollee's hospital stay.

The use of limited provider networks has enabled some of the projects to secure special discounts for their enrollees that supplement any other discounts that the contracting HMOs, PPOs, or indemnity carriers negotiate with providers. Getting hospitals to bear part of the cost of enrollees' medical services is clearly advantageous when trying to create affordable health plans. However, negotiating with hospitals requires a lot of work and, because facilities serve local populations, discounts secured in one city may not be easily replicated when projects attempt to expand to other areas.

Lessons on Building Public-Private Partnerships

1. *Developing public-private partnerships to expand health insurance to the uninsured is a difficult and time-consuming process.*

In developing their initial business plans, project organizers could not foresee all of the obstacles before them and underestimated the time needed to form their partnerships and bring their products or services to market. Initially, most thought they could begin enrollment after a relatively short 18 month planning and development phase. However, most took between 24 and 33 months and one project took 43 months to begin enrollment.

In developing their programs, these projects had to attract an insurance company or HMO to underwrite and sponsor their product(s). They had to negotiate with insurers on benefits, cost-sharing provisions, medical underwriting arrangements and premium rates. They had to establish networks of providers and negotiate payment arrangements and utilization control mechanisms. They had to develop marketing and advertising plans. They had to create or adapt products which would provide the desired benefits and yet still be affordable. Furthermore, all of these activities require ongoing assessment and refinement as the product is developed, pretested and implemented through the early enrollment phase.

The program's short development and funding cycle was viewed with suspicion by insurers, because they operate on a longer-term cycle than public policy demonstrations or government budgets. Joseph Davis, President of the Medimetrix Group and a member of this Program's National Advisory Committee, has observed, "It's hard to be taken seriously by this industry...if you can't show that you're going to be around for a long time."

2. *Insurers are competitive and bottom-line oriented. To keep the price down for small employers they have relied on extensive medical underwriting.*

Insurers have limited their risk in this market by:

- Excluding individuals based on their medical history. The industry uses a computerized medical information bureau to cross-reference an applicant's medical history.
- Excluding industries because their employees are perceived to be higher risks by virtue of the type of work they perform or the type of employees they attract.

- Limiting coverage by excluding specific illnesses for a defined period (often one year) or for that condition for the life of the policy.
- Using selective marketing to those firms thought to represent better risks.
- Using premium pricing strategies including age and sex tiers and durational rating (offering low premiums initially and then raising the premium significantly after 18 months to two years).

Indeed the major obstacle that the projects had to address in trying to attract an insurance partner was the industry's perception that the small employer market represents a much higher risk than the large employer market. While most of the projects were forced to adopt some underwriting practices in order to enter into a partnership, the projects proved that "underwriting is negotiable". For example, the projects were generally able to limit the number of excluded industries.

3. *The projects found that HMOs were generally more receptive and compatible partners than indemnity insurers.*

Few indemnity insurers were interested in trying something new and financially risky. According to the project director for Colorado's SCOPE, Judy Glazner, it's not easy "to try to achieve social goals" using an industry "oriented to the bottom line."

In contrast, working with HMOs was often found to be easier. HMO benefit packages normally include preventative and primary care and many base their premiums on community rates to a greater extent than indemnity insurers. Also, most HMOs already have relationships with providers which include risk-sharing arrangements and utilization control mechanisms.

4. *Insurance partners and providers require project organizers to have a strong business orientation.*

Building such public-private partnerships requires a strong business perspective and commitment. Project directors need to have not only a grasp of public policy issues, but also an understanding of how to run a business. Many found outside consultants to be invaluable in the areas of benefit design, actuarial analysis, and marketing.

Project directors also need to understand what motivates insurers and providers. For example, executives from Complete Health, Inc. the HMO that sponsors BasicCare in Birmingham, view their participation not only as a public service but also as a business opportunity to learn more about small employers; they feel such knowledge would be especially valuable if public policy makers pass reforms for this market.

Lessons on Developing Benefit Plans and Products

1. *Insurance plans developed by these projects provide insight about what small employers consider acceptable "basic benefits."*

An important task in fashioning solutions to our health insurance crisis is to identify a set of basic, or "core," benefits to provide access to what could be considered an adequate level of health services. The projects responded to the needs of small employers by fashioning plans that provide hospital services as well as good preventive and primary care services. In designing their plans, the projects faced difficult tradeoffs in trying to cover a wide variety of services with reasonable volume limitations, to minimize cost-sharing provisions, and to lower premiums. Products such as Alabama's BasicCare, which drastically limit the variety and volume of benefits, have not generated the anticipated volume of enrollees.

2. *Small employers are not interested in very limited benefit plans; if purchasing insurance, they want hospital coverage and benefits similar to large employers.*

Through surveys and focus groups, the projects found that small employers believe hospitalization coverage is an essential feature for health plans and they are not interested in

products which substantially limit this benefit. Small employers are very sensitive to premium prices, yet want fairly comprehensive coverage similar to plans offered by large employers.

3. *Major cost sharing can be used to lower premiums significantly.*

Denver's SCOPE plan illustrates how major cost sharing can be used to lower premiums significantly. The plan covers a wide array of preventive and primary care services with no deductibles or coinsurance. However, an individual could spend up to \$2,750 per calendar year for other services covered by the plan. By requiring enrollees to share the cost of inpatient services in this way, the project is able to offer SCOPE to small businesses for about 40 - 50 percent less than other comprehensive products in the Denver market.

Lessons on Marketing

1. *Small employers are a "tough sell," requiring aggressive marketing and advertising.*

Projects that have not made a substantial investment in marketing and public relations have generally had disappointing enrollment growth.

One reason it is hard to sell health insurance to small employers is because they are often difficult to reach and unavailable to meet with sales representatives. Most are busy managing daily operations and involved in the production of products and services. According to Ree Sailors, "Small employers are tough to get a hold of. Their offices are in their trucks, their records are in their shoe boxes, their checkbooks are in the truck and at home, they're on their car phones, in phone booths, and they're using their customer's phones when roofing the house."

It is not surprising that uninsured small business owners, especially those with ten or fewer employees, are generally unfamiliar with the administrative and technical aspects of group indemnity or HMO products. Most small businesses operate on a cash flow basis, with very thin profit margins, little or no accumulated surplus, and a concern over the need to limit overhead and control expenses. They certainly do not have full-time staff in charge of personnel or benefit matters as larger businesses have.

2. *Marketing efforts should be targeted not only to small business owners, but also to uninsured employees and their dependents.*

These projects found that it was important to advertise directly to employees, as well as employers, in the hope that uninsured workers will then push their employers to purchase insurance. The projects used a variety of strategies to raise awareness of their products, including paid television, radio and newspaper advertisements; public relations and publicity efforts; and even billboards.

3. *In addition to advertising, public relations efforts should be used to inform the working uninsured about insurance alternatives.*

The projects have found public relations efforts to be an effective means of targeting the working uninsured for two reasons. First, projects have been able to stretch their advertising budgets by emphasizing the important public service they are providing. Second, news reports and human interest stories can help explain the unique features of their products and identify the target population more effectively than traditional advertising.

Lessons about Enrollment and Utilization

1. *These demonstration programs have primarily attracted very small businesses ("microfirms") averaging 2.9 employees and 5.2 enrollees.*

As of May 1, 1991, the projects had enrolled over 40,000 persons, as shown in Table 4 below. The average business has about 2.9 employees, including both those who have enrolled and those who have chosen not to enroll, and the average size insured group has 5.2 lives, including enrolled employees and their dependents. These are very small businesses, or

"microfirms." One reason firm size averages are so low is that the groups include a significant number of self-employed individuals and their families. This finding is important because some state and federal proposals to mandate employers to offer insurance benefits would exempt many of the smallest firms, such as those with five or fewer employees. However, these projects demonstrate that it is these same small firms that are most in need of more affordable health insurance products.

With over 20,000 enrollees, the Washington Basic Health Plan accounts for about half of the total number of lives enrolled. This program targets individuals rather than employment-based groups, and is therefore able to meet the needs of part-time workers, seasonal laborers and others who can not receive coverage through the work place and do not qualify for government programs.

TABLE 4
Enrollment and Firm Size Data
As of May 1, 1991

Project	Months Enrolling	Lives Enrolled	Firms Enrolled	Average Firm Size ²	Average Group Size ³
Arizona Health Care Group	40	2,935	892	n/a	3.3
Maine Managed Care Insurance Demonstration: MaineCare	29	1,100	333	2.0	3.1
Washington Basic Health Plan ⁴	28	20,700	n/a	n/a	n/a
Tennessee Primary Care Association: MedTrust	25	924	236	1.9	3.9
Florida Health Access Corporation	23	5,934	1,262	2.5	4.7
Michigan Health Care Access: One-Third Share Plan	23 ⁵	972	186	2.4	5.2
Wisconsin Small Employer Insurance Project	22 ⁶	319	82	1.9	3.5
Colorado: SCOPE	20	6,938	682	4.5	10.2
Utah Community Health Plan	19	1,497	257	3.5	5.8
Central Alabama Coalition for the Medically Uninsured: BasicCare	13	308	44	4.2	7.0
Totals		41,627	3,974	AVG:2.9	AVG: 5.2

2. *Even with premiums 25-50 percent below market rates, these projects believe that fewer than 20 percent of uninsured small firms will purchase insurance voluntarily.*

To date even the most successful projects have only been able to attract approximately 10 percent of the uninsured small business market, a modest but significant accomplishment. The enrollment experience of the projects suggests that many uninsured small firms and their employees are willing to accept plans with some limited benefits, restrictions on providers and some cost sharing requirements if the price is right. The right price to achieve this level of market response seems to be roughly 25 to 50 percent below prevailing premiums for small

²Firm size data include all employees in a firm, whether or not they are enrolled in the project's insurance program. Due to data collection constraints, Wisconsin and Denver have reported only the number of enrolled employees and Utah has estimated its figure.

³Group size data include enrolled employees and their dependents.

⁴With grant funding under the Health Care for the Uninsured program, Health Systems Resources organized managed care networks that are utilized by the Washington Basic Health Plan. However, the BHP receives no direct funding from The Robert Wood Johnson Foundation. Data regarding firm and group size are not applicable, because the BHP insures individuals and families directly, not through employment-based groups.

⁵Michigan project stopped enrolling new members on April 15, 1990.

⁶Wisconsin project stopped enrolling new members on January 1, 1991.

employers. As discussed above, the other major factor driving enrollment is marketing. Those plans that have effectively marketed their products to small employers have a higher number of enrollees.

3. *Early utilization of health services by demonstration enrollees is lower than anticipated and lower than national averages.*

Insurers' reluctance to pursue the small business market is based in part on their fear of adverse risk selection. But the early utilization experience of some of the projects indicates that this fear may not be justified. Early data for project enrollees show utilization of health services to be lower than anticipated and, lower than national averages, as shown in Table 5.

TABLE 5 Utilization of Inpatient Services			
Project	Hospital Discharges per 1,000 Members	Inpatient Days per 1,000 Members	Average Length of Stay in Days
Arizona Health Care Group (7/1/89-6/30/90)	99.7	258	2.6
Florida Health Access (6/1/89-4/1/90)	79.0	267	3.4
MaineCare (7/1/89-6/30/90)	108	264	2.5
HMO Average Enrollees Under Age 65 (1988)	80.9	358	4.4
National Average Enrollees Under Age 65 (1988)	95.6	519	5.2

Sources: Alpha Center, GHAA Annual HMO Survey, National Hospital Discharge Survey

Inpatient days per 1,000 members have been about 70 percent of the national HMO average and about 50 percent of the nationwide average. Average length of stay figures have also been lower, except for the Arizona project. On average, enrollees under these demonstrations have used fewer inpatient days and have had lower lengths of stay than other persons enrolled in HMO and conventional insurance plans.

These early utilization experiences are positive signs for those seeking to broaden coverage to the currently uninsured because they indicate that small groups may not use more hospital services than large groups. However, enrollment in the plans is still low and the plans have been operating for a relatively short period of time. Further research is needed to account for the effect of preexisting condition requirements and demographic differences in the project-sponsored plans versus other plans.

Chairman STARK. Thank you very much.

Ms. Glazner.

Ms. GLAZNER. Yes, I would only like to add one or two things to what David said. I am director of the Denver project.

It took us almost 2 years to find an insurance partner. I think that that is not something to underestimate. It was very difficult to get the insurance industry to underwrite this product. We had no subsidy. They had to take the full risk.

The other thing is, from my estimates, we have spent \$33 in advertising for every single person we have enrolled. That is very high.

Chairman STARK. Did you want to add anything, Ms. Sailors?

Ms. SAILORS. I would just add that what we have done in Florida is to create a State-sponsored buying cooperative, which is to provide technical assistance to the small group market. So that the point I would like to make over and over again is if you have a three-man mechanic shop, the employer doesn't have the time or the inclination to be able to shop in today's market. And I think one of the things that you need to do in thinking about subsidy strategies as well is to place the subsidy in with technical assistance so that you can leverage it to the hilt. And that is what we have tried to do in Florida with our program.

Chairman STARK. Mr. Polk, you are going to tell us about COSE. Proceed.

STATEMENT OF JOHN J. POLK, EXECUTIVE DIRECTOR, COUNCIL OF SMALLER ENTERPRISES, CLEVELAND, OH

Mr. Polk. Thank you, Mr. Chairman.

My name is John Polk. I am the executive director of the Council of Smaller Enterprises, which is part of the Greater Cleveland Growth Association, Cleveland's chamber of commerce. The Growth Association is the largest local business organization in the country with about 10,600-member companies. Of those, about 10,200 have exercised the excellent business judgment of identifying themselves as members of the Council of Smaller Enterprises.

Why are we the largest organization of our kind in the country? One of the primary reasons is that we operate one of the largest and arguably most successful group health care programs for small employers in the country. Of our 10,000-member companies, about 8,000 currently participate in at least one of the dozen or so group health care programs that we sponsor for our members' use. Those 8,000 companies provide coverage to 60,000 workers a total of about 145,000 lives when you add in the workers' dependents. And our members will invest a combined \$165 million in group health care premiums with the carriers whose programs we sponsor this year.

A number of things are fairly unusual about our programs. First, while our group is very large as a group, the individual components are very small. The average size of a company participating in our programs has eight employees. Two-thirds of our member companies have fewer than five workers. So our program has been demonstrated to be successful where the demographic problem apparently is.

We survey every company which joins our organization and which elects to participate in our group health care programs. Twenty percent of the companies whom we survey on average tell us that prior to their having joined our organization, they had no access to group health care coverage for their workers, either by dint of their being brand new companies or by dint of their being so small that they were not attractive in the commercial marketplace.

Our program does not exist for uninsured workers, but as a consequence of our management of the program, we have managed to keep costs down to a point at which they are affordable for even the smallest employers.

Third, our members who do participate in the plan and were insured before save big money from participating in our programs. A company which has been purchasing insurance and which elects to join our organization, participate in our health care plan, sees their premiums decline by somewhere between 35 and 50 percent based on the case.

Finally, our insurer is making money. Not as much money as they might like, but we are a profitable piece of business. And when you are doing business with a Blue Cross and Blue Shield plan, that is unusual enough these days.

Finally, over the last 7 years, the cost of health insurance coverage for individual small companies in the Cleveland market has increased a total of about 176 percent since 1984. In a similar period, the prices that our members pay for health insurance coverage have increased a total of 45 percent.

These are all things that the experts tell you you are not supposed to be able to do in the small group market, which is one of the reasons that we rely on entrepreneurs, as opposed to experts, to operate our plans.

There are a number of reasons that I think we are successful, to the extent that you consider us so. First, clearly, is our size. We have not always been as big. In the last 5 or 6 years, our program has doubled in size. But size does buy you negotiating leverage in your local marketplace, and also provides you with a high degree of actuarial credibility, which means it is very predictable within a group of 145,000 people what kind of utilization you can expect. It is unlikely that our insurer will make a mistake in pegging our prices from year to year.

That actuarial credibility also provides individual member companies with some protection from significant premium increases as a result of an individual shock claim which a small company might experience. It is unusual in the small group market.

Second, we manage our program very aggressively, both to enforce accountability on our insurers, as well as to make certain that our members play by the rules. We have some very simple and very straightforward rules that govern eligibility for enrollment in our plans. We enforce them very aggressively to make certain that our members either advertently or inadvertently do not cheat the membership generally.

Being an advocate for our members in this marketplace is—

Chairman STARK. Could you outline those rules for us, those simple tough rules?

Mr. POLK. Simple rules like you have got to enroll all your full-time employees. You can only enroll your full-time employees. You have the option to define what constitutes a full-time employee. Any employee working between 17.5 and 30 hours a week you can identify as a full-time employee.

Chairman STARK. But not below 17.5?

Mr. POLK. Rarely below 17.5.

Chairman STARK. OK. What else?

Mr. POLK. We have established some very good exclusions so that, for example, an employee who is a spouse of a worker who receives coverage through another health insurance plan is not required to be insured under our program. When insurers require working families to double cover themselves, it basically gives insurers a reason to squabble over who gets to pay the claim and also enhances cash flow for the insurers.

And we do audit our members' payrolls to make certain that they are playing by the rules, and we will kick out companies that do not clean up their acts.

But advocacy for our members in this marketplace——

Chairman STARK. Don't you medically underwrite?

Mr. POLK. We do do some medical underwriting.

Chairman STARK. Such as?

Mr. POLK. Such as if you have an active metastatic disease at the time that you apply for coverage in our plans, you probably won't get in. People who are already ill do not need health insurance coverage. They need a cheaper way than retail to pay for care that they are very likely to need to receive.

We do have an information system which helps us to keep a little bit ahead of our insurance carriers and be more knowledgeable about what is going on in our programs from day to day than our insurers.

Let me add a couple of other thoughts. I want to echo one of the previous speakers who said that probably the most important component of our program has been a very successful partnership with our primary insurer. This is the hardest thing to find in this marketplace. All our knowledge, all our management skill and excellent information system are going to do us very little good unless we can find a commercial carrier or, in our case, a Blue Cross and Blue Shield plan willing to do business a little differently in order to achieve our common goals. We have been very fortunate to find an insurer willing to do business with us in that area.

Now, COSE operates in the current environment, in the real world. We have got to adhere to all those State insurance mandates that everybody says such bad things about. We get no tax breaks from anybody. We do not get a lot of help from our elected officials in State government. But I do think that our program shows that it is possible to address the twin problems of access and affordability in health care coverage in the private sector, in the voluntary marketplace, if we are willing to be creative and to pursue those goals relentlessly and in a businesslike way.

I welcome your questions.

[The prepared statement follows:]

STATEMENT ON
before the
for the
SUBCOMMITTEE ON HEALTH
of the
HOUSE WAYS AND MEANS COMMITTEE
for the
COUNCIL OF SMALLER ENTERPRISES
by
John J. Polk
Executive Director
May 23, 1991

Mr. Chairman and members of the subcommittee, my name is John Polk and I am the Executive Director of the Council of Smaller Enterprises (COSE), located in Cleveland, Ohio. The Council of Smaller Enterprises (COSE) is the small business division of the Greater Cleveland Growth Association, Cleveland's chamber of commerce.

Overview

With more than 10,000 members, COSE is the largest local small business organization in the United States. COSE's mission is to promote economic development by supporting entrepreneurship and small business.

Of the 10,000 members, about 8,000 member companies participate in one of 12 group health care programs, which are available through six carriers operating in Northeastern Ohio. Our plans are representative of health care benefits available in our marketplace; our plans are designed to match the needs and buying habits of our local marketplace; our plans are managed to be affordable and flexible.

The average size of a COSE company is seven employees, which is important given that the demographics of the working uninsured show that the largest number of people who work but have no health care coverage are isolated in companies with less than 25 employees.

Without COSE, approximately twenty percent of our participating

companies tell us they would be unable to obtain health-care coverage. Among these companies are sole proprietors, brand-new firms, very small companies who can't afford the expense and companies that for various reasons do not qualify for coverage from other sources.

We have come a long way since 1973, when we began our adventure in a naive attempt to make group health -care coverage as available and affordable as possible for our members.

Many people and institutions thought our goal was impossible. Fortunately, we didn't know it couldn't be done, so we went ahead and achieved our goal.

Our philosophy, objectives and achievements are based on small principles. COSE is not unique; it does not exist in a vacuum. We were merely the first to apply these principles to the health insurance problems small businesses face.

The private sector, when innovative and determined, can address group health-care coverage in a creative and practical way. We believe COSE's experience will help organizations and institutions throughout the U.S. approach the thorny issue of group health care coverage from a fresh perspective and create workable solutions.

Toward a New Model

In finding a way to achieve our goals, COSE developed some principles and practices which were -- and apparently still are-- radical in the small business community.

In 1983, we created an independent entity, Group Services, Inc. This entity was the one centralized customer to which our insurance carriers would ultimately be accountable. The easiest way to describe Group Services, Inc. is to describe what it is not.

We are not a multi-employer trust, a multi-employer welfare arrangement, a Taft-Hartley trust, or a 501 (c) (9) volunteer employee benefits association. Group Services, Inc. is a purchasing group. Our structure is that simple.

Information is Power

To begin to control costs, we had to identify what we didn't know about our plans, and then we had to obtain that information. What didn't we know? almost everything. We didn't know the number of companies or the number of people in our plan or our total annual premium.

When we asked our primary carrier, Blue Cross and Blue Shield of Ohio, how many of our companies were in the plan, we couldn't get an answer. At first, we thought the carrier just wasn't telling us, but we discovered that the carrier actually didn't know.

We did know that despite our size, which we estimated to be 15,000 employees, our rates were increasing just about as much as they would if we were a company with 15 employees.

Furthermore, we believed that it made no difference whether a group of 15,000 employees represented hundreds of small businesses or one large business. Our group of 15,000 employees should be no more of a risk than any other group of the same size.

In order to provide the best package we could for our members, there were three things we had to do: centralize administration, act like a customer and make a long term commitment.

Centralized Administration

The cost for a health-benefits program has two components: first, risk; and second, administration.

We figured that if the risk component was constant, then the difference between our costs and the a big business's costs must lie in the fact that instead of one big corporate bill we had thousands of tiny bills. So we turned our attention to the administrative aspects.

To establish a solid information base, we needed to centralize the

administration of our plan. The main role of Group Services is to handle enrollment, billing and reimbursement functions with all our carriers.

We knew our insurance carriers did a pretty good job of managing risks and paying claims. We also know our carriers didn't perform billing and enrollment functions economically. We figured it would be far more efficient to centralize billing and enrollment, which represent 18 - 30% of administrative costs.

Usually, total administrative costs represent anywhere from 5 - 15% of the carrier's premium. Through Group Services, COSE's cost is under 1%: 0.89%.

Fully 40% of our member companies whom we audit have problems meeting the eligibility rules. In half the cases, people are in the health-insurance plan who don't belong there; we want them off. In the other half of the audits, we find full-time employees who are not insured; we want them on.

Our job is to help our carriers enforce the rules. We have penalties for noncompliant companies, up to and including expulsion.

Acting like a Customer

Second, to serve our members effectively, we also had to change our relationship with our carriers by acting like a customer, not a captive audience. We wanted to persuade our carriers to sell us what we wanted to buy, not what they wanted to sell.

To do that, we found we first had to monitor important data, such as what services our members used and who received benefits. This information is absolutely essential in our negotiations with our carriers for an equitable package for our members.

Long-term Commitment

Third, a long-term approach is essential to the success of a group health care program. When we created Group Services, Inc., we did not want to make the best deal for one year or the best deal for everybody for all time.

What we did want was the maximum benefit for the most people over time. We sought stability and predictability.

COSE members may be able to find another health care coverage deal that will beat our price for one year or even two, but over the long run they get a better deal through COSE than they could get on their own.

From 1984 to 1990, COSE experienced a cumulative 34.5% increase in health care premiums, compared to increases of 154% charged by commercial carriers to small groups in our marketplace.

In 1984, we negotiated our first three year contract with our primary carrier, something unheard of among insurance carriers. Today our minimum contract runs three years, and we have a two-year renewal option in most of our contracts. That long-term commitment helps shape our program's future evolution.

Why it works: size matters

Size is not everything, but it is an essential asset. First it gives us valuable negotiating strength. Our current annualized premium, paid by over 8,000 member companies, is more than \$150 million.

Of that sum, close to \$130 million went to one carrier, Blue Cross & Blue Shield of Ohio, which provides us with 10 plans, including a Preferred Provider Organization (PPO) and a Health Maintenance Organization (HMO). In fact, one out of every ten people in Cuyahoga County, where Cleveland is located, carries a COSE Blue Cross & Blue Shield of Ohio Card.

When we meet with Blue Cross's president, we often begin the meeting by giving him a premium check for \$6 million. That reminds him that we're an important customer, and it enables COSE to negotiate far more aggressively on behalf of our members than any individual COSE company could do on their own.

Our negotiating strength has enabled us to build safeguards into our agreement that guarantees us stability in prices. These safeguards are tied to

objective measurements of inflation in our marketplace and of changes in the utilization of COSE's plans.

Size, risk and predictability

Our size gave us another important advantage. We were able to secure better rates because our size greatly increased the predictability of our actual claims and reduced our insurance carriers' risks.

The universe of insurance underwriting is founded on the knowledge that a predictable percentage of a population will experience certain health conditions that require treatment. In this universe, unfortunately, small groups have much less predictable results than large groups. But as the size of the group grows, its actual claims experience can grow progressively closer to what was predicted.

With 150,000 lives in COSE's universe, our insurers are able to predict with confidence that certain events will occur -- a factor known as actuarial credibility. The larger and more diverse the group, the greater the likelihood that the group will behave the way the actuaries predict it will.

By treating us as a single customer rather than thousands of tiny unpredictable units, our carriers are able to place greater reliance on their utilization assumptions. This allows our carriers to lower their charges for assuming risk and in turn to provide us with better insurance rates.

As inclusive as possible

We do underwrite our groups, and we have designed our underwriting rules to be as fair as possible to both our present and future members because we believe the maximum number of our members should be able to participate in a predictable, stable plan.

By contrast, when insurance carriers design underwriting specifications, they are as exclusive as possible in order to keep out the maximum number of questionable risks.

Our underwriting rules are tight enough to screen out individuals whose health care requires subsidy. Our rate of underwriting turndowns is less than 20%.

No matter how inclusive we make our underwriting rules, there are still problems we cannot solve alone. The most pressing is how to provide coverage for very small groups which have individuals who are uninsurable because of pre-existing medical conditions.

Conclusion

COSE's success is built on five key factors. We have the advantage of tremendous size. Our size has enabled us to exert maximum leverage. We have built long term commitment into our contracts. We have taken a strongly proactive approach to management. And we have a good working relationship with our major carrier.

As a result of all these factors, COSE has produced an innovative program which provides a wide variety of options to our members at costs which are as much as 40 - 50 % lower than the plans which small businesses purchase independently in our community.

Our experience over an 18-year period in a competitive environment has convinced us that it is indeed possible for small business owners to provide good health care benefits at the best price possible.

Mr. Chairman, thank you for allowing me the opportunity to share the COSE story with you. I would be happy to answer any questions that members of the subcommittee might have.

Chairman STARK. Thank you very much.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

My first question is to Mr. Polk. Can this be replicated? Are you trying to replicate it in other communities?

Mr. POLK. We are currently working with a couple of other local chambers in the State of Ohio, in the Toledo area as well as in the Akron area. Because of our relationship with our insurer, it is unlikely at this time that we would be able to take our program across State lines because of the weirdness of the manner in which Blue Cross and Blue Shield plans operate. But there is no question. We have been in business in Toledo since January. We have already got about 100 companies signed up for that program. We have got several hundred already operating in the Akron and Lorain County areas. There is no question but that this type of program can be replicated.

Mr. GRADISON. Dr. Helms, with regard to the subsidies, one thing I haven't been able to sort out in my mind is how we deal with the fact that while the health uninsured, that is, those who are employed or dependents of employees—are concentrated among small employers, there still are quite a few people covered by small employers. Therefore, a generalized subsidy which relates, let's say, to the size of the enterprise is going to provide a lot of benefits to people who are doing this already.

Maybe that is inevitable, and there is just some leakage or extra cost. But do you have any suggestions just conceptually of how to interface there?

Mr. HELMS. We face the same problem. We didn't want to offer subsidized products to those that already had insurance.

I guess my answer is that with such higher costs for administration and marketing, if you want to rely on this employer-based system and you want to keep it voluntary, then it seems to me we have to level the playing field. And, yes, that may benefit some employers who already have insurance, but the subsidy is warranted. There is no legitimate basis for why a small employer should be paying significantly more for their health insurance.

Mr. GRADISON. I find that a very helpful and straightforward approach. In other words, we may just have to anticipate that that will be part of the cost.

One of the problems I had with the Pepper Commission recommendations was that I thought that their recommendations with regard to the small group market would actually increase the cost. I don't say that was the intention, but I felt that was a likely result. And one of the reasons I said that was because I have been struck by how small a group can self-insure these days. I appreciate there are hazards in self-insurance, but most folks in the insurance industry as well as among employers tell me that when you are down to about 100, it is not out of the question, especially if you protect yourself against catastrophic losses by some form of re-insurance, which is available generally.

What that has led me to believe is that an attempt to re-create a community rating may be flawed from the very beginning in the sense that the groups which consider themselves low cost. I am not talking about five employees. Let's say 105 employees. Those

groups that consider themselves low cost could avoid paying that average rate by self-insuring. You might end up with a pretty expensive community rate. Or to put it another way, it seems to me that a lot of people say, well, gee, if we hadn't ever gotten away from community rating, we wouldn't have all these problems today. This may be true, but the other thing that has happened since the glorious days of community rating is the increase in self-insurance.

Unless we figure out how to relate that to these changes, I think we may be creating as many problems as we solve. Do you have any thoughts on that conundrum?

Mr. HELMS. I think I basically agree with you that our objective should be to be rethinking conceptually this whole third-party arrangement. To me the answer lies in finding ways to pool larger groups together. I mean, there are systems that don't do it by each individual employer. There are other countries, as you know, who have an employment-based system, but they don't pool by the basis of individual employers.

It is hard to go back to community rating without, obviously, solving the self-insured problem. But I think the objective of Government should be to try to get a situation which pools these groups. There was a time when the young subsidized the older and didn't feel that that was wrong. There are times when the healthy subsidize the sick. I don't think we mind doing that. But the issue comes down to creating a fair pool. And if people get to stay outside the pool, that is not fair. So I think you have to solve the self-insurance issue. I think we should be trying to look creatively for how we find new ways to stabilize these pools so that we can get some averaging going on.

Mr. GRADISON. Finally, do you have any comments on what is going on in Cleveland? It sounds like you have arrived at a different conclusion than they have.

Mr. HELMS. I am not sure that is true, but I think Ree Sailors should answer because she is trying to do the very same thing. Conceptually, my answer is that it takes substantial market penetration, and the history for multiple employer trusts conceptually is that they get rated. The good risks get pulled out over time as insurers find those larger firms and those healthier firms. I think a model that mirrors the COSE experience and builds on it is the buying cooperative idea of Florida. Ree could tell you a little bit about that.

Ms. SAILORS. I think what we are trying to do is a couple of things, and one of them is to pool the small employers together into an organized buying group and to do it on the consumer side, not the marketing side, not to the benefit of the insurance industry. I think a lot of times you have seen pooling happen for marketing facilitation, but not necessarily for risk or for leveraging it for rates. So what we have tried to do is to take the consumer approach to the pooling, not the insurer's approach to the pooling. I think John and I share that in terms of COSE and Florida Health Access.

I think the other thing that is important is that I think that health care is still a local marketplace; therefore, pools have to be replicated. I don't think it is realistic, given how health care is de-

livered, to think that you can have giant national pools or anything like that. I think health care is a local marketplace. Therefore, if you want to operate effectively in that marketplace, you have to be at that level and use your leverage at that local level in that local marketplace.

So that is what we are trying to do, and so in each marketplace around our State—we are in 16 counties now—we go in, find out who the players are, organize our market, and leverage and negotiate on their behalf.

I think in addition to that, too, that you do have companies who, no matter what, even with the pooling—whether it is risk pooling a la community rating or pooling a la getting negotiations and everything—you ultimately still have the requirement for subsidy. It is very clear to me, if I were to give you a profile of my member companies—which we are only in business 2 years. We are different from John's membership a little bit. On average, my companies have less than three employees, or if we have to round them up to whole numbers, they have three employees. I am dealing with micro businesses. I am dealing with a lot of family businesses. Over 95 percent of our enrollment has fewer than five employees. I have 1,400 companies now who previously did not have health benefits.

The average age of the workers in these companies is 28 years old; 30 percent of them are children; 32 percent of the workers have never had health coverage in their lifetime before they came into this program. And of the 68 percent who have had coverage before, they have been out of coverage on average 18 months before they get to this program.

Their earnings, including the owners of these businesses, are between \$16,000 and \$17,000 and \$18,000 a year, including the owners. There is very small difference between an employee and an owner in this segment of the market.

Consequently, I think that you have to work on this pooling mechanism to empower them and also to attempt to marshall their resources. It is a match. It seems to me the equation is how do you bring people into the health care financing equation who are not presently able to participate. And the nonparticipants in a heavy way are small business owners and their employees. They do have some money, and it is the benefit they most want to give and would most like to have. And so what we have tried to do is to extend a bridge that says to them we will provide the technical assistance, we will help organize the market into a buying group, we will provide some risk sharing through reinsurance, and we will marshall your resources in conjunction with the State's and create a match program that is at least as good as or better than Medicaid match.

So it creates a marshalling consequence that is different from just simply having people who can afford it go ahead and do it. Like David has mentioned, too, one of the things that we have done is marketed straight at only employers who did not provide health benefits to their employees.

Mr. GRADISON. Thank you. Thank you for your indulgence.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. Thank you, Mr. Chairman.

Ms. SAILORS, yours is a premium subsidy program in the State of Florida?

Ms. SAILORS. We have several forms of subsidy in our program. We have direct and indirect subsidies. In terms of the indirect subsidies, the State of Florida defrays the administrative and marketing costs by supporting our corporation with appropriations. So our operating expenses for administration—and we do monthly premium billing and collection; we do sales, marketing, eligibility determination, medical underwriting, et cetera. All that is done by us, and that cost is absorbed by a State appropriation and not passed into the premium.

Mr. CHANDLER. How much is that per year?

Ms. SAILORS. The total appropriation to the program at this point is about \$4 million. What we are dealing with right now, we are in developmental stages, so we have high front-end development administration core costs that are there.

Mr. CHANDLER. You are still fairly new? I have forgotten how long—

Ms. SAILORS. Yes, we are about 2 years old and just really expanding this year. So consequently what we see is—well, let me tell you about the other forms of subsidy, and then I will give you a per-capita cost. That will help.

The other kind of subsidy that we do is we target a family subsidy to our family tiers, knowing that is hard for workers to get their dependents covered because of the slacking off of the employer participation in premium sharing. So consequently we target a subsidy at family rates to try and make them more affordable. Consequently, we have 30 percent of our enrollees coming in as kids. That is another form of direct subsidy that goes straight at the family rating.

Mr. CHANDLER. Does Florida exempt your participants from the State-mandated benefits?

Ms. SAILORS. We can if we wish to. We have not exercised that right; indeed, we have all the State-mandated benefits.

What we found is that it seemed like a non sequitur to talk about mandated benefits when we knew that the reason the cost was higher—and I am sorry, I remember now that you filed the bill. But if the cost that drives the premium of small groups up is attributable to higher administrative and marketing costs, then why attack the benefit package as the solution? It doesn't seem like that is the sequitur that you want to go for. What you need to attack is the administration and marketing costs. Why we decided to use that strategy in Florida is let's go after what is dragging that price up.

Mr. CHANDLER. I am going to ask John Polk some questions. I would just ask why make people take something that they don't want. But I want to get to Mr. Polk.

Ms. SAILORS. Can I respond to that one?

Mr. CHANDLER. Well, if you do it quickly because we have limited time.

Ms. SAILORS. The reason is we did market research on the uninsured population of workers and their employers and asked them what they wanted. And we gave them options of a traditional plan, catastrophic only coverage, and a comprehensive package. What

they overwhelmingly selected was a comprehensive package with predictable out-of-pocket exposure because of their limited incomes. And what we asked the employers was, What would you prefer? They often selected a traditional 80-20 product. When we asked them, What do you think is in the best interest of your employees? They changed their answers to the managed care HMO models that we had in the questionnaire. So we followed our own market research in terms of what we heard the public asking us for.

In addition, we market two plans——

Mr. CHANDLER. OK. I have limited time, and I want to get on to John Polk.

Chairman STARK. Take all the time you want.

Mr. CHANDLER. Oh, all right. Thank you. I didn't mean to cut you off.

Ms. SAILORS. That is all right.

Mr. CHANDLER. He is sometimes in a good mood and sometimes he isn't. You just never know what to expect. [Laughter.]

Ms. SAILORS. I am sorry. This is my first time here.

We also give our customers an option of a higher and lower benefit option, and they tend to buy the higher option with the more comprehensive benefits. We found that a single parent with two children who has to take her kid to the pediatrician for a \$45 office visit and a \$15 prescription has just blown her budget for 6 weeks. To her that is almost a catastrophic experience. What we are seeing is a very clear demand for that kind of front-end coverage and a nonwillingness to invest their dollars if they cannot perceive the value of immediate value. They have to displace spending in order to get this benefit and are willing to do so if they see value attached, and that means front-end benefits as well as the catastrophic.

Mr. CHANDLER. Yes, but that is pretty basic health care, and in vitro fertilization, which is mandated in Texas and some 800 other benefits, you know, that is what we are trying to get away from.

Ms. SAILORS. Yes.

Mr. CHANDLER. So I don't have any quarrel with what you just said, but if you could get the politics out of this a bit and——

Ms. SAILORS. Well, and John has got hairpieces, I think.

Mr. POLK. In Minnesota, actually.

Mr. CHANDLER. In Minnesota, that is correct.

John, the point about the administrative and marketing costs, could you comment on that for COSE? How you have been able to reduce costs?

Mr. POLK. Sure. Let me go back, though, and talk about State mandates first because a significant component of the incremental additional administrative costs that insurers must charge their small group subscribers have to do with the costs of administering State mandates; that plus the sort of tendency of providers to increase prices when reimbursement for their services is mandated under State law, make State mandates not always a good thing. I could argue about the advisability of some of them in a social context, but certainly the chiropractors and hairpiece makers and the herbalists and others whose coverages are sometimes mandated under State law should probably be subject to sort of free market forces there.

The administrative costs attributable to our program are running right now about 11 percent of annual premium, in comparison with the average cost of marketing in small groups. Now, insurers will tell you their average administrative cost is 15 percent. How do they get to that? Well, they take the 6 percent that they charge to large groups and the 28 percent that they charge to small groups, combine them and divide them by 2, and you get 17 percent, 15 to 17 percent.

In the State of Ohio, the commercial insurers operating in our State are charging currently as much as 30 percent of annual premium to cover the cost of administration. A significant portion of that is related to sales cost. Your friendly neighborhood insurance agent will, generally speaking, take about 10 percent of annual premium to compensate himself for having processed your application to an insurance company. We do not use brokers in the sale of our plans, and it has not impeded the growth of our plans or the effectiveness of our administration a whit.

We have also focused primarily—and I would say something to echo one of David's comments. In a group of people, especially a group of 145,000 people, there is not going to be a whole lot we are going to be able to do to manage the risk component of our program. I mean, people are going to get sick, and when they get sick, you have got to take care of them.

We have really focused in our program on negotiating hard with our insurers on the administrative side of our equation. And, you know, among the reasons that our savings are significant for our member companies, not just because of size and actuarial credibility but also because in comparison to the general small group marketplace, our administrative costs are very low, a little bit more than half of the administrative costs which Blue Cross and Blue Shield charges to their other sort of non-COSE small businesses.

Administrative and marketing costs are a very big component of the additional cost of coverage for small employers, and it also happens to be the segment of cost which is least regulated by State governments, by and large. So it is where insurers have a tendency to make their money in the small group market.

Chairman STARK. Would the gentleman yield for a moment?

Mr. CHANDLER. Yes.

Chairman STARK. I would like to say just for the record, hairpieces in Minnesota, which becomes a subject of derision, are only available to cancer patients who have lost all of their hair as a result of chemotherapy or other treatment. I would suggest that a one-half of 1 percent reduction in what we pay radiologists would buy hairpieces for those people for the next 100 years.

As to a prosthesis for a mastectomies, hospice, or some gentle help to the sickest of the sick, I think we should be very careful because I think this committee would have the heart to provide those benefits. The real mandated benefit that costs people money are alcohol, drug abuse, the private psychiatric hospitals, mental health care, which cost, I would guess, 99 percent of mandated benefits. Now, if we want to deal with that, we could. But I find this mandated benefit issue is often an excuse for people who I think would decide to provide mental health care and drug abuse and alcohol abuse.

I just say that because too often it is like studying frogs under the National Institute of Science or something. I think we should be careful how much blame we are willing to dump on that, because it could come back to haunt us here. I just add that as—

Mr. CHANDLER. I would tell you I know quite a bit about drug and alcohol treatment and its cost. I think because of third party—

Chairman STARK. You would support it, would you not?

Mr. CHANDLER. Absolutely.

Chairman STARK. Yes.

Mr. CHANDLER. But not mandating it. I think that employers will buy insurance for that because it is cheaper to treat a drug addict or an alcoholic than it is to fire a person and hire a new one. So I think they are going to provide the coverage, and they will do it because they want to, not because some legislature somewhere decides that they should.

Mr. POLK. Mr. Chandler, I would also point out that one of the unfortunate consequences of most State mandates is that it adds some rigidity to the local marketplace. You know, we will talk about mandates all day long because I think that in many cases mandated benefits as a cause are kind of a red herring in this discussion. There are things having to do with the delivery system that I think if you fixed, you could afford to do a lot better stuff for more people.

Chairman STARK. Precisely. That is exactly the point I wanted to make.

Mr. POLK. But in the case of outpatient substance abusers as an example, because of the way that State mandate is written in the State of Ohio, we are not as an organization able to bargain with a limited number of providers to make that coverage available more effectively and on a most cost-efficient basis for the sake of our members. We have got to reimburse anybody that hangs out a shingle. That is a consequence of the enactment of that State law.

Mr. CHANDLER. There are some real shysters out there for exactly that reason, and the market could have a great impact on that.

Mr. POLK. I would say that in States where the outpatient subsidy is \$550 a year, people get cured for \$550 per year. In States where the outpatient subsidy is higher, \$3,000 a year, people get cured for \$3,000 a year.

Mr. CHANDLER. Alcoholics Anonymous costs \$1 a meeting and works better than any of the other models.

You have been more than generous, Mr. Chairman. Thank you.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman. I just want to get to a couple of other issues.

First of all, I need to hear you talk a little bit more about preexisting conditions. Some of you have addressed it, but we are not going to do the job that needs to be done if we exclude people with preexisting conditions. I appreciate the problem of somebody with active cancer in treatment. Could you each talk a little bit about how you deal with preexisting conditions and on what basis do you drop a participant? Can a participant be guaranteed continued participation as long as they pay their premiums and, in the case of COSE, play by the rules?

Mr. POLK. Let me just talk about our program. In the 20-year history of our program, no company which has paid its premium has ever had its insurance coverage canceled as long as it has played by the rules. We do not believe in preexisting health conditions that would enable an insurer to exclude individual employees from coverage. The rules that we have negotiated with our insurer require our insurer to accept or reject the entire group on the basis of medical underwriting rules that we negotiate with our carriers. I think that that does a couple of things.

First, it provides our insurer with a little bit more of an incentive to deal with marginal preexisting health conditions in order to get the entire group.

Second, our ability to negotiate those rules with our insurer assures us that the insurer is making generally decisions on some rational and supportable basis, which is not solely financially driven.

Mrs. JOHNSON. Could you describe the rules?

Mr. POLK. It is kind of hard to do in 25 words or less. But I would say first that a company with—I will use myself as an example. I have got a little bit of asthma, and I take some prescription drugs fairly regularly. Were I an employee in a five-employee company and I had asthma, another guy had high blood pressure, and a third person had diabetes, for example, it would be real hard for that five-employee group to get coverage.

Generally speaking, we can work with those member companies and our insurer to make certain that those insurers have figured out a way to manage the costs of those kinds of health conditions. I think that very often when we talk about preexisting conditions, we have a tendency to focus on real tragic anecdotes, people with very serious diseases who, because the heartless insurer has made a difficult decision, finds himself without coverage.

We find that the primary health-related barriers to coverage are those kind of routine, chronic, not incredibly expensive but sometimes difficult to manage health conditions like diabetes and asthma and high blood pressure, which are controllable but which do have costs. Within our group, there are about 500 companies that currently require a subsidy from the remainder of our membership of about \$11 million a year because of the health conditions of those groups. We believe that that is what our association's plan is for.

Mrs. JOHNSON. In other words, you allow the insurer to look at those issues, but then you can also negotiate with the insurer so that group can't be excluded?

Mr. POLK. That is correct. Unless there are a sufficient number of sufficiently serious health conditions in a group. I would say that our rate of turndowns is about half of the rate of turndown in most commercial insurance programs. Many, many more—an increasing number of those turndowns come from companies who are not willing themselves to adhere to our enrollment rules, for example, and our eligibility standards, and less and less are coming by dint of health reasons.

Chairman STARK. Are you suggesting about a 20-percent turn-down rate?

Mr. POLK. Depending on the month, somewhere between 15 and 20 percent, yes. That is up a little bit over previous periods.

Mrs. JOHNSON. What about your rules that make it hard for companies to comply?

Mr. POLK. Well, there are an awful lot of employers out there that really don't want to provide coverage to all their full-time employees or who wish to provide coverage to employees on a 100 percent employee contributory basis, or who wish to insure some of their part-time workers but not all of their part-time workers. And we make the rules for participation very clear. And if you don't want to play by our rules—

Mrs. JOHNSON. In other words, you have to cover all your employees? You can't participate in your—

Mr. POLK. All your eligible employees or up to an acceptable percentage—in larger groups, we require that 85 percent of the eligible employees be covered. We have various exclusions for participation in HMO programs and for spousal coverage and for other things, so that an employer can reduce the number of employees who might be considered eligible.

But once you get down to that number of eligible employees, you have got to have pretty much all of them.

Mrs. JOHNSON. Do you have a comment?

Mr. HELMS. Well, I guess the first point to say about it is it is very regrettable in this country that we have to resort to this. I think the sad part of our work on these demonstrations trying to promote public/private partnerships is that we didn't have a deep pocket of the Federal Government or the State government, and we too had to do this. I think ours are much more benign than are traditional in this industry, but I think it is regrettable. And I think you have to look at what we have done to create the fragmentation of the insurance market. That is the fundamental thing to say.

Ree can tell you a little bit about what we are doing, and over time as these projects evolve, the theory behind it is that we will be able to relax those things that we do have to do.

Ms. SAILORS. One of the things, we do medical underwriting on our groups, reluctantly but we have found that we could not find an insurer who would be willing to partner up with us without it. And so we do it, but to give you an idea of how we—we control it instead of the insurer, and we set the underwriting standards ourselves. That is a point of negotiation with a risk-bearing partner.

A typical indemnity company, traditional insurer, might reject 15 to 30 percent of their applicants under medical underwriting. We reject 3 percent. We are very careful about it, and one of the big things that helps in our percentages and everything is we also accept pregnant women into our program. That is a complete—never heard of it in the small group market kind of thing. That has a lot to do with preexisting conditions.

Once they are in the group, it is like an all-or-nothing kind of thing. We use HMO services for our groups. We contract with HMO's to provide health care services to our groups. And so once they are in, they are in. One hundred percent of their body is in and none of the parts are excluded; you know, none of that kind of thing, and so they get the full comprehensive set of services that the HMO provides to all of its members. And we do not deny renewal on the basis of experience or claims.

Mrs. JOHNSON. Last, just very briefly, we need to know how you handle mental health and drug abuse needs, because they are big cost drivers. But we have to be brief, because we have got a lot of panels waiting. Any comment on that?

Ms. SAILORS. Mental health benefits are included in the basic HMO package in our State under our State laws and everything. But we do have a basic plan there. They are entitled to 20 outpatient visits a year with a copayment and an inpatient hospitalization of 30 days with copayments.

Other than that, we do not have any additional mental health benefits which are available as options, which we have opted not to select at this point. We are more interested in the basic coverage.

Mrs. JOHNSON. Thank you. Ms. Glazner, from Colorado?

Ms. GLAZNER. There are mandated benefits in Colorado, and we cover them to the extent that they are required to be covered. What we do have, as we have for everything beyond the primary care physician visit, is a 50-percent coinsurance. That does keep utilization down. This program makes a profit, and we think it is largely because of our cost-sharing arrangements and its low price, believe it or not.

Can I say one thing about medical underwriting? Our company has actually made the statement that they think that high-cost claims are much more random than the insurance industry thinks and that there is no empirical or experience basis for medical underwriting. And they are starting to look at some of their data to try to determine if, in fact, medical underwriting saves them anything.

I think this is a question that deserves a look.

Mrs. JOHNSON. Thank you.

Mr. POLK. I would expand on that thought to make the observation that primarily insurers conduct medical underwriting practices looking over their shoulders at one another as opposed to at the integrity of their own groups. It is a competitive practice more than strictly technical practice devoted to protecting the integrity of their groups. It is to keep them from being selected against by other competitors in the marketplace.

Our inpatient benefit for mental health and substance abuse is very generous in comparison with most commercial plans. We offer 45 days of inpatient care. On the outpatient side, we do what the State of Ohio tells us we have got to do. The rate of recidivism is very high; it is a very expensive benefit.

Mrs. JOHNSON. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Could I just follow right on there on the last two comments? What I am hearing you say—and I have always been somewhat skeptical about health insurance as insurance. It seems to me it has always been looking back at last year's cost and knocking them up 5 percent and hoping that this year we don't have a colder winter.

What I am hearing Mr. Polk say is that it is really to keep your program from getting dumped on, so that a big insurer says, Uh-oh, I got this little plant with a whole bunch of folks with emphysema because they all smoke, I will create that as a separate division of my company, and put them into COSE, and I will stay self-insured, and therefore they take the older risk or actually active disease

risk and try to sneak them in under what limited medical underwriting you do. Is that the pin you are putting——

Mr. POLK. We have had a lot of activity in the past where agents have taken, for example, all the retirees in Company X and dumped them into the COSE plan. For several years in the late 1970's and early 1980's, we were operating a guaranteed issue community-rated plan.

Chairman STARK. You were?

Mr. POLK. Yes, which made our program the most attractive program in town for people who were old and sick.

Chairman STARK. I would think, yes.

Mr. POLK. But nobody who did not have a preexisting health condition found it particularly attractive.

Chairman STARK. Do you have a flat rate?

Mr. POLK. We practice a variation on community rating. Over the course——

Chairman STARK. Can you give me an approximation so I can kind of compare it with Dr. Helms? I am just trying to get some sense of——

Mr. POLK. Yes. Let me qualify it a little bit because any number that I give you is a——

Chairman STARK. Give me a range.

Mr. POLK. We invented a number which we call cost per contract month. That is just the number of people who hold certificates and the volume of premium on a monthly basis and volume of premium divided by the number of people who hold contracts. It doesn't count family coverage and single coverage, stuff like that. It is about \$195 a month.

Now, Cleveland, OH, is one of the most expensive cities in the country in which to get sick, so I am not certain how that compares with other——

Chairman STARK. What you are saying, for an individual the cost is averaging \$195——

Mr. POLK. For the typical contract. Once again, we are talking about single coverage versus family coverage, and the plans——

Chairman STARK. But per individual then when you are all——

Mr. POLK. Right. If we are negotiating with our insurer, we say it is \$195 per contract month. That sort of blends over funding mechanisms and cost sharing and a bunch of other things.

Chairman STARK. And you have a standard benefit package?

Mr. POLK. We offer our members the opportunity to participate in 12 different types of plans.

Chairman STARK. So this \$195 takes the average, or——

Mr. POLK. Right. You take everybody who is in the plan, divided by the number of premium dollars per month, and that is about \$195.

Chairman STARK. What is your core package, 80/20——

Mr. POLK. No, our core package, our most popular plans, are the kinds of plans you can't buy anymore. They are first dollar coverage plans which reimburse on a UCR basis, and we have a variation on that program which delivers the same level of benefits in a closed panel hospital setting——

Chairman STARK. Does your core plan have an out-of-pocket cap?

Mr. POLK. The core plan features a supplemental major medical benefit, which has a \$400 deductible per family and 80/20 coinsurance up to \$2,500. I mean, it is very generous.

Chairman STARK. That is very interesting. Dr. Helms, in your strategies, basically, your reforming small group practices is saying that we have to have open enrollment and limit medical underwriting or do away with it and some kind of rating control. I gather that is key to what you think we have to do?

Everybody suggests that we have a self-insured problem, the ERISA problem, which I presume is that the only people who go into self-insurance are those who say gee, all our workers are under 30, why should we pay the rates that include everybody—which is arguably an age-related risk problem.

If a subsidy or a level playing field is fair, a quick answer to that is that there ought to be the reverse of a subsidy, that is, a benefit tax or a premium tax for those who have all the low-risk employees to subsidize the high-risk employees and level the playing field.

I don't know if that would be a popular approach, but it would resolve the problem I think that you were getting at or several of you have mentioned in ERISA.

Let me ask you this. We have just 5 minutes. What would you think, if we were just to, as I have suggested and others have suggested, go to a single-payer system? I find a lot of trouble with employment-based.

All of you have to keep hanging on to that, but the practical matter is that half the uninsured work parttime, so as good a job as you can do, we are still going to end up with half the uninsured in your community not fitting into your program—or anybody else's program. They also probably tend to be down around between one and two times the poverty level or they won't play.

I mean, this play or pay thing is fine, but I can tell you exactly where they will play or pay. If it is pay at \$100 and you cost \$195 to play, they aren't going to play. They are going to pay the \$100, and then somebody has to subsidize the \$95 to get them into COSE.

I mean, I don't say that with any prejudice. That is just good business sense. If we kick up the pay penalty to \$195, everybody is going to join the COSE plan, and we still aren't going to take care of the part-timers or the duplicately insured people.

Do you have a problem with going to a social-based system and then giving the people the option to come into your program? Do you care, Mr. Polk, if I waved my wand and said that everybody in your fair city has to be in this program? They join yours, they get a tax credit. If they don't join yours, they pay a tax that puts them into, say, Medicare. Let us not say Medicaid for a minute.

And if they bring a note from their employer to the tax collector, they don't have to pay the tax, and we then become competitive. Our benefits would not be as generous as what you offer, so the incentive is there. Does that trouble you?

Mr. POLK. Let me give you maybe two quick answers. First, as the staff guy for a Chamber of Commerce, I would have to say, we will fight you on the beaches, we will fight you in the skies, we will never surrender.

Chairman STARK. I understand that. [Laughter.]

Mr. POLK. But your Scud missiles will never outdo my Patriot. [Laughter.]

On the other hand, let us leave aside the political practicability of enacting a single-payer system in the country. It is clear to me that our biggest challenge as employers and as government leaders is to find an adequate way to address the problem of employees who exist at the seam, both of public programs and of private programs.

The challenge is to create some type of public-private partnership that would enable us to use the employer-based system for individuals who have jobs, to use the employment-based system in partnership with some type of public subsidy to enable people who have jobs to obtain the efficiencies of an employment-based—and may I say, purchaser-driven—health care system.

One of the things that I think we fear about a socialized medicine system is there is very little incentive, absent Government dictate, to enforce efficiency and costeffectiveness in the delivery of services.

But I really, I would welcome the challenge of trying to work with our government leaders to help us figure out how to deal with those people on the seam. Half of the people who are working but are uninsured earn less than \$10,000 a year. For those individuals, full employer-paid coverage is going to amount to a 30 percent increase in their compensation. That is a bad business decision.

If we could create some way through an extension of Medicaid, for example, to create a public-private strategy which would mesh to enable us to cover those people at the seams, that would be an enormous service, I think, to the uninsured of this country.

Chairman STARK. Do you have any trouble with that?

Mr. HELMS. I would emphasize that in our strategies, we were looking not just to work on the small business of side of this. In looking at an overall solution, one of our projects that has developed through Washington State, the basic health plan, has a subsidized product for individuals.

I think you are absolutely right that the solution to this isn't just working on the small market segment. You also have to worry about individuals.

Chairman STARK. Unfortunately, time is about to end. You have been generous with your time and a very enlightening panel. I appreciate it, and if everybody we worked with could be this cooperative and willing to help us compromise to find a solution, I think we would get done a lot quicker.

I thank all of you, and will look forward to working with you more in the future. Thank you for being with us.

We will recess for 10 minutes, at which time we will have our next panel.

[Recess.]

Chairman STARK. We will resume.

Our next witnesses are a panel consisting of the National Restaurant Association, represented by W.W. Naylor, president of American Restaurant Services; the National Federation of Independent Business, represented by Carolynn Miller; and the Health Care Account Project represented by Barry Weinstein, its president.

All of the written statements will appear in the record in their entirety. Mr. Naylor, would you like to proceed in any manner in which you are comfortable?

STATEMENT OF W.W. (BIFF) NAYLOR, PRESIDENT, AMERICAN RESTAURANT SERVICES, INC., LOS ANGELES, CA, AND MEMBER, BOARD OF DIRECTORS, NATIONAL RESTAURANT ASSOCIATION

Mr. NAYLOR. Mr. Chairman, members of the committee, I am Biff Naylor, president of American Restaurant Services. We own and operate The Original Mels in Sacramento, Two Pesos Restaurants in California, and two Cindy's Coffee Shops in northern California. I also serve on the board of directors of the National Restaurant Association.

I appear before you today to talk about my experience with a group called the American Restaurant Employers Trust. I am a co-founder of the trust, which got its start when a group of restaurant employees banded together in 1975.

The group's mission has been and continues to be very simple: To make it easier for restaurateurs to provide health benefits for their employees.

I am here today to ask you to give the trust and other groups like it a chance to prove that when the cost of health insurance goes down, more employers begin to offer benefits.

The food service operator's problem with finding insurance—as you may know, most insurers are not clamoring for clients in the restaurant industry. More often, we are turned down or offered coverage at prices we cannot even begin to afford. Let me list a few reasons why this happens.

Restaurants are small businesses. Many insurers won't even consider selling to businesses with fewer than 35 full-time employees. This eliminates a whole sector of our industry. Insurers see restaurants as risky businesses. The restaurant business is extremely competitive, and profit margins are notoriously low, averaging about 3½ percent.

Restaurants experience high employee turnover. The typical food service employee is likely to be young, unmarried, and work part-time. All of these qualities lead to greater turnover, which insurers shy away from.

Restaurants often do not have the ability to pass the costs of higher benefits on to our customers. In our industry, passing on costs can be the economic equivalent of suicide, and when many restaurants barely turn a profit—even in the best of the times—squeezing profit margins is not an option either.

For all these reasons, providing health benefits has become one of the greatest challenges for the independent restaurant operator, and this is where we believe the trust is making a difference. Basically, the trust has integrated two industries that have been at odds in the past.

Let me describe our program. First, the trust is fully insured. Major insurers assume all medical risks. Trusters bear no risk.

Second, we believe in choice. The trust offers five basic health insurance plans to food service operators with a full array of HMO,

PPO, indemnity, life, and dental products. Most of our options have no deductible, and require employees to pay only nominal amounts for each visit to a physician. We have found that these cost control factors appeal especially to the entry-level restaurant employees who do not have a great deal of disposable income.

Third, we are committed to the philosophy of managed care as both cost effective and a better option for most people.

Fourth, our coverage is aimed at regular employees, not just owner-managers. Our underwriting guidelines require 75 percent of eligible employees to participate in the employer's plan, and we require employers to pay at least 50 percent of premium costs to make insurance more affordable for our employees.

Fifth, the trust's programs do not provide Cadillac benefits. They are, however, tailored to meet the needs of food service employers and employees. Our plans are affordable and give employees basic protection against catastrophic costs.

Sixth, as a trust run by restaurateur trustees and specifically geared toward the restaurant industry, we are able to act effectively as the intermediary between our industry and health care providers. In many ways, insurers operate by rules that don't exactly fit restaurants. A middle-man like the trust is what is needed to take the time to craft the health care packages that work best for restaurant employees.

All of these factors are working. Over 100 food service employers now buy insurance through the trust, resulting in coverage for about 2,500 workers and 1,500 of their dependents. Our goal for 1991 is to grow by 25 percent. Taking the first step toward expansion this year, we began to offer benefits in Utah.

We have had excellent experience with our costs and have not had to increase rates in the last year. What we have found is that the restaurant industry is a good industry to insure with the proper controls.

For now, we are looking at options like 24-hour coverage, a combination of workers' compensation insurance and accident and health benefits. We are also hoping to provide portability of trust benefits, where employees could move from job to job and carry their health benefits with them with no waiting time.

Mr. Chairman, I know that the Nation faces a grave problem with health care access. I know that many employers in my industry do not now provide insurance. But I can also tell you that we want to, that cost is our main obstacle, and that research shows that as restaurants grow larger and more profitable, they do offer health benefits.

We are excited about our work with the American Restaurant Employers Trust. Our success demonstrates a simple truth that cutting costs will increase coverage. I ask Congress to do all it can to cut costs and let the free enterprise system work.

No. 1, give small companies the 100-percent tax deduction for health care expenses, just like corporations.

No. 2, allow Federal law to preempt State mandates for trusts like ours and small employers. An effective way to do this is to support Congressman Chandler's bill, the Small Employer Health Insurance Incentives Act, that will be introduced today.

No. 3, take at least a first look at COBRA. From our point of view, this program is not working well.

And No. 4, provide some relief in the area of malpractice costs. Experts have attributed as much as 25 percent of health care costs to malpractice liability.

Mr. Chairman and members of the subcommittee, the situation is complex. I'd like to think that programs like our trust will be given every fair chance to prove their worth before Congress resorts to more drastic actions, actions that could literally cripple businesses like my restaurant.

Mr. Chairman, thank you again for this opportunity to present my experiences as well as the views of the National Restaurant Association. I would be happy to answer any questions.

[The prepared statement follows:]

**Statement of W.W. (Biff) Naylor, on Behalf of American Restaurant Services, Inc., and
the National Restaurant Association**

Mr. Chairman, members of the committee, I am Biff Naylor, President of American Restaurant Services, Inc. We own and operate The Original Mel's in Sacramento, Two Pesos Restaurants in California and two Cindy's Coffee Shops in northern California.

I also serve on the Board of Directors of the National Restaurant Association. This organization is the leading trade association for the U.S. foodservice industry, which employs eight million workers at more than 657,000 establishments. 1991 industry sales are projected to hit \$241 billion.

I appear before you today to talk about my experience with a group called the American Restaurant Employers Trust. I am a co-founder of the Trust, which got its start when a group of restaurant employers banded together in 1975. My company now serves as the Trust's manager. The group's mission has been and continues to be very simple: To make it easier for restaurateurs to provide health benefits for their employees.

I'm here today to ask you to give the Trust and other groups like it the chance to prove that when the cost of health insurance goes down, more employers begin to offer benefits.

The foodservice operator's problem with finding insurance

As you may know, most insurers are not clamoring for clients in the restaurant industry. More often, we are turned down -- or offered coverage at prices we cannot even begin to afford it. Let me list a few reasons why this happens:

- Restaurants are small businesses. Many insurers won't even consider selling to businesses with fewer than 35 full-time employees. This eliminates a whole sector of our industry. About 70% of eating-and-drinking places have gross sales under \$500,000 and, typically, employ far fewer than 35 full-time workers.
- Insurers see restaurants as risky businesses. The restaurant business is extremely competitive and profit margins are notoriously low, averaging about 3.5%
- Restaurants experience high employee turnover. The typical foodservice employee is likely to be young, unmarried, and to work part-time. All these qualities lead to greater turnover, which insurers shy away from.

As I mentioned, even foodservice operators who are offered the chance to buy insurance often cannot afford to. Premium prices can be exorbitant: As small businesses, restaurants seeking health insurance face fixed administrative costs and a smaller pool of employees over which to spread risks.

Foodservice operators are typically not in a position to exercise cost containment or, like many larger companies, to self-insure in order to bring down costs.

And restaurants often do not have the ability to pass the cost of higher benefits on to our customers. In our industry, passing on costs can be the economic equivalent of suicide. And when many restaurants barely turn a profit in even the best of times, squeezing profit margins is not an option either.

How the Trust helps

For all these reasons, providing health benefits has become one of the greatest challenges for the independent restaurant operator.

And this is where we believe the Trust is making a difference. Basically, the Trust has integrated two industries that have been at odds in the past. We have used our knowledge

Statement of W. W. (Biff) Naylor
Multi-Employer Trust Testimony
May 23, 1991

of both the restaurant and insurance business to come up with insurance plans for restaurateurs that are profitable for both industries -- and, most important, of benefit to employees.

Let me describe our program:

1. First, the Trust is fully insured. Major insurers assume all medical risk -- trustors bear no risk.
2. We believe in choice. The Trust offers five basic health insurance plans to foodservice operators, with a full array of HMO, PPO, indemnity, life and dental products. There is a range of programs to meet the budgets of restaurants of all sizes.

Our three lowest-priced options offer managed-care coverage through Health Maintenance Organizations. Most of our options set no deductible and require employees to pay only nominal amounts for each visit to a physician. We have found that these cost-control factors appeal especially to the entry-level restaurant employees who do not have a great deal of disposable income. Because of the low costs, these workers are much more likely to use health services before serious problems arise.

3. We are committed to the philosophy of "managed care" as both cost-effective and a better option for most people. With managed care, which I believe is the wave of the future, employers pay their costs up-front. Doctors are able to practice medicine and specialize, not get dragged down in the details of running an office. Because of the way we pay, it's in the doctors' interest to keep employees well.
4. Our coverage is aimed at regular employees, not just owner-managers. Our underwriting guidelines require 75% of eligible employees to participate in the employer's plan. And we require employers to pay at least 50% of premium costs to make insurance more affordable for our employees.
5. The Trust's programs do not provide Cadillac benefits. They are, however, tailored to meet the needs of foodservice employers and employees. Our plans are affordable, and give employees basic protections against catastrophic costs. What's more, our experience shows that companies that start out offering lower-cost packages gradually add on more coverage as their experience with our plan proves successful.
6. As a Trust run by restaurateur trustees and specifically geared towards the restaurant industry, we are able to act effectively as the intermediary between our industry and health care providers. In many ways, insurers operate by rules that don't exactly fit restaurants. A middle-man like the Trust is what is needed to take the time to craft the health care packages that work best for restaurant employees.

All these factors are working. Over 100 foodservice employers now buy insurance through the Trust, resulting in coverage for about 2,500 workers and 1,500 of their dependents. Our goal for 1991 is to grow by 25%. Taking the first step towards expansion, this year we began offering benefits in Utah. The companies in our plan range from small independents to fast-food franchisees to larger companies.

We have had excellent experience with our costs and have not had to increase rates in the last year. What we've found is that the restaurant industry is a good industry to insure, with the proper controls.

Statement of W. W. (Biff) Naylor
Multi-Employer Trust Testimony
May 23, 1991

We're now looking at options like 24-hour coverage, a combination of workers' compensation insurance, accident and health benefits. We're also hoping to provide portability of Trust benefits, where employees could move from job to job and carry their health benefits with them with no waiting period.

In conclusion

Mr. Chairman, I know that the nation faces a grave problem with health care access. I know that many employers in my industry do not now provide insurance. But I can also tell you that we want to; that cost is our main obstacle; and that research shows that as restaurants grow larger and more profitable, they do offer health benefits.

We appreciate the difficulties Congress faces in solving the problem. But for those of us who operate in the real world of running a business, the mandated approach will not work. If a company can't afford health insurance today, a mandate from Washington won't make it affordable to tomorrow.

We are excited about our work with the American Restaurant Employers Trust. Our successes demonstrate a simple truth: that cutting costs will increase coverage.

I ask Congress to do all it can to cut costs and let the free enterprise system work. I see huge movements in California on the health care front, especially in managed care. Please make it possible for all employers who wish to provide health insurance for their employees to be able to do so. I ask you specifically to:

- Give small companies the 100% tax deduction for health care expenses, just like corporations.
- Take at least a first look at COBRA. From our point of view, this program is not working well. The administrative and recordkeeping burdens on small businesses are simply prohibitive and contribute to health care costs.
- Allow federal law to preempt state mandates for Trusts like ours and small employers. These constantly increasing state mandates keep adding to the cost of health insurance.
- Provide some relief in the area of malpractice costs. Experts have attributed as much as 25% of health care costs to malpractice liability. Many doctors are performing unnecessary tests to protect themselves, while at the same time paying exorbitant premiums.

Mr. Chairman and members of the subcommittee, I urge you to be willing to chip away at this problem in increments: The situation is complex, and I'd like to think that programs like our Trust will be given every fair chance to prove their worth before Congress resorts to more drastic actions -- actions that could literally cripple businesses like my restaurants.

Mr. Chairman, thank you again for this opportunity to present my experiences as well as the views of the National Restaurant Association. I'd be happy to answer any questions.

Chairman STARK. Thank you.
Ms. Miller.

STATEMENT OF CAROLYNN E. MILLER, LEGISLATIVE REPRESENTATIVE, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, WASHINGTON, DC

Ms. MILLER. Thank you, Mr. Chairman. My name is Carolynn Miller, and I am representing the National Federation of Independent Business. I am here today to talk about solutions.

As you know, NFIB has done several comprehensive studies in the area of health care and small business. Through those studies over the past decade, we have found that the No. 1 problem facing small business is the cost of health insurance.

Ninety percent of NFIB members find health insurance to be prohibitively expensive. Two out of three uninsured businesses did not provide coverage because it was too expensive, and if the business was uninsured, the owner and his or her family was also likely to be uninsured.

A recent Money magazine survey received nearly identical results. In both surveys, it was cost, not cold heartedness, that determined whether or not insurance was offered as a fringe benefit.

A surprisingly distant second problem for small business is the pure availability of coverage. Some businesses are finding it difficult or impossible to get any type of insurance coverage.

The majority, however, find that their access to health insurance is restricted, not because the carrier refuses to provide coverage, but rather because of the costs of that policy.

NFIB believes that the focus of this debate should be upon affordability of health insurance and health care. NFIB strongly supports insurance market reforms, and we need the savings that would result from a stabilized marketplace. But the cost of the policy remains the most important problem.

If you enact insurance reforms, many of which will raise costs, without ensuring that those policies are affordable, access to health insurance will continue to decrease.

Today, there are a few common strategies being used by small businesses to reduce costs. These include shifting more of the costs to employees through higher deductibles, higher co-insurance, and premium sharing. These are not being very readily or happily adopted by small business owners.

Other devices include purchasing catastrophic-only plans and paying for minor expenses out of pocket. Few small businesses are able to participate in networks or in HMO's. Luckier small businesses have access to multiple-employer trusts or other groupings, but these have not been widespread nationally to have a significant impact on the access issue.

Few other strategies exist for small businesses to use to reduce costs, and these devices have, in our opinion, been only marginally effective. Other, more effective, measures can be enacted by this committee. I will go through them, but they are not in order of importance.

First, provide small firms with the same benefits and protections given to large, self-insured plans. Exempt them from State health

insurance mandates. Broad-based preemption, which simply permits small firms to be given treatment equal to over 60 percent of the business community. Further, preemption would save these businesses scarce premium dollars.

Second, provide unincorporated firms with the same tax treatment that incorporated firms get. Enact H.R. 784 to give them the full 100 percent deduction for the costs of health insurance. One-quarter to one-half of the working uninsured could be taken care of through this one simple approach.

Third, provide individual purchasers with the same tax subsidy that businesses receive. Restore the EZ-Form tax deduction for individuals, and exempt individual policies from costly State mandates. Both of these proposals would help to make insurance affordable for individuals.

Fourth, encourage full implementation of managed care principles. Preempt State antimanaged care laws.

Fifth, reinvigorate consumerism and control medical inflation. This can be partially accomplished by simplifying the flexible savings accounts, enacting cost containment measures spelled out in our testimony, reforming the medical malpractice field, and encouraging open competition.

Finally, work to reduce the government's influence on the marketplace. Reform COBRA and other Federal entitlement programs.

Help for small business is vitally important. If properly done, it will have a tremendous impact and make a tremendous dent in the number of working uninsured and will help to keep people covered by health insurance.

However, complete reliance upon employment-based health insurance will never solve the entire problem. Only through providing options to businesses and to individuals, strengthening community-based programs, and searching for nontraditional, noninsurance mechanisms can we ensure that all Americans will have access to quality health care.

Thank you for the opportunity to testify. I look forward to your questions.

[The prepared statement follows:]

NFIB

National Federation of
Independent Business

STATEMENT OF

Carolynn E. Miller
Legislative Representative
Federal Governmental Relations

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

SUBJECT: Small Business Access to Affordable Health Care and
Health Insurance

BEFORE: House Ways and Means Subcommittee on Health

DATE: May 23, 1991

On behalf of the more than 500,000 small business owner members of the National Federation of Independent Business (NFIB), I am pleased to participate in this hearing. NFIB's membership mirrors the national business population in its make-up. This parallel to the general business community and our large membership base are particularly important as it provides validity to the numerous studies the NFIB Foundation and the NFIB have conducted.

Small businesses have always been a dynamic force in the American economy. Millions of Americans own and operate small businesses. Over 19 million Americans report income or losses from business activity and self-employment is the principal job for over 13.8 million of our fellow citizens. Of the 10.5 million jobs created in the past decade, a vast majority were created by small business. Small business employs over half the work force and provides income for millions of families.

To better understand and evaluate the health insurance issue, NFIB has conducted three comprehensive surveys. These surveys, conducted in 1978, 1986 and 1989, reveal the practices, opinions and attitudes of small business owners. Other surveys have been conducted to fill in the gaps. These surveys are unique in the field and are the basis of today's testimony and our "Access for Small Business" strategy.

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The Guardian of
Small Business

Introduction

The number one problem facing small businesses today, and for the past seven years, remains the rising cost of health insurance. It was the number one problem when NFIB surveyed its members in 1983, in 1986, and again in 1990.

This presents you and others in the public policy arena with a two-fold dilemma. The first dilemma is cost as a barrier to businesses seeking to offer health insurance for the first time. The second, and an increasing problem, is rising costs jeopardizing current coverage.⁽¹⁾ Thus the so-called small business problem is actually two problems with one common root -- rising costs -- and that core problem acts as a barrier to access for all small businesses nationwide. Without affordable health insurance and reasonable health care costs, there can be no discussion of increasing the number of covered Americans.

The core problem of rising costs is fueled by two distinct forces, medical inflation and counterproductive government intervention. Both of these must be addressed in order to bring long-term stability to the marketplace and to enable businesses and individuals to purchase quality, but affordable, health care. This does not mean that there is no role for government programs. To the contrary, expanded incentives and reforms in the insurance marketplace and increased competition in health care services will never solve the entire problem. Government programs, such as expanded community health centers, are necessary to fill the gaps and to reach those in the urban areas where the problems are of a different, and greater, magnitude.

The causes of the cost crisis are numerous and are the result of not allowing the marketplace to operate efficiently. These causes can be divided into five generic categories:

1. Medical inflation. The demand for newer and better services is, of course, met with an overwhelming supply of both, but this occurs in a market that does not have the traditional checks and balances fostered by competition and information. Add the increased demands spurred by Medicare, Medicaid, and state mandated coverage, and the result is raging inflation.

2. The cost shift from the federal government and self-insured businesses. The so-called savings achieved in Medicare and Medicaid are not the result of more efficient medical practices, but rather are the result of businesses picking up the remaining portion of the federal government's unpaid bills. Not only is the private sector paying for the care provided to federal program beneficiaries that is not reimbursed, it is the small business community that is shouldering the bulk of that burden. It is the small, non-self-insured business that is unable to negotiate discounts or enter provider networks that are hit the hardest by the cost shift.

3. Imposition of government erected barriers. These barriers include state health insurance mandates; state anti-managed care laws which limit flexibility and cost savings; COBRA, which drives up the cost of insurance for current employees; and ERISA, which distorts that marketplace.

4. An unpredictable and distorted insurance market that rejects the time-honored insurance principle of the law of large numbers and cross subsidization.

5. Usurpation of individual choice and responsibility, coupled with a tax code that discriminates against non-employer-based health insurance purchases and purchases by unincorporated businesses.

State of Small Business and Health Insurance

As mentioned previously, for small business workers and their employees, access to health insurance and quality health care is determined by cost.(2) Cost also explains a recent phenomenon -- the slight decline in the number of small firms offering health insurance as a fringe benefit.(3) Cost prevents new firms from offering health insurance(4) and jeopardizes the continuation of existing health insurance benefits.(5)

The cost of health insurance can be the greatest payroll line-item cost in a small business -- many times exceeding the combined cost of workers compensation and liability insurance.(6) Exacerbating the problem, a majority of small firms pay 100% of the premium cost. These same businesses have little access to managed care or cost-containment measures because of the incessant churning that is occurring in the marketplace. In addition, small firms are unable to obtain the benefits of self-insurance(7) and therefore must comply with expensive state-mandated benefit laws(8), pay state premium taxes, and shoulder a larger portion of the carrier's administrative expenses.(9) Further, churning has resulted in higher tracking costs and brokers commissions.

Small businesses are reaching the peak of the frustration level.(10) This reluctant call for help comes as a result of the clash between values and reality. Small business owners believe that every American has a right to health care.(11) Small business owners also desire to offer health insurance as a fringe benefit out of both a sense of familial obligation (12) and competitive necessity. (13) However, the reality of 20 to 300% premium increases, a low profit margin (14), struggling regional economies, and restricted cash flow impairs the business' ability to purchase health insurance.(15)

Two thirds of small businesses offer health insurance.(16) In general, these firms tend to be more mature, more profitable, and have more full-time employees than their counterparts that do not offer health insurance.

Despite being fairly stable, these small firms experience high initial premiums and higher renewal premiums. Frequently-cited reasons for the high cost of health insurance for small firms include:

- o Insurer fear of adverse selection.
- o Instability of the firm.
- o Lack of expert help in choosing plans.(17)
- o Little negotiating clout.
- o Strict experience rating.
- o Nature of the small business work force:
 - * labor intensive
 - * high percentage of part-time employees(18)
 - * high percentage of older workers
 - * high percentage of very young workers
 - * more remedial workers
 - * high turnover
- o High administrative costs for the carrier.
- o Insufficient experience data.
- o Absence of preferential treatment afforded to larger firms.
- o Imposition of state premium taxes and mandates.

For those not offering health insurance, the following factors have been consistently identified as the most common inherent barriers to offering health insurance:(19)

- o Cost of premiums or past increases too great.
- o Insufficient profits.
- o Insufficient cash flow.
- o Employee turnover too great.
- o Too many employees covered elsewhere -- secondary wage earners.
- o Too many part-time employees.
- o Too many older employees.
- o Employees prefer cash compensation.
- o Too small to receive group "discounts".
- o No suitable cost-containment options available.(20)

However, it is interesting to note that two out of three of those not offering health insurance want to because they believe it is in the firm's best competitive and moral interest to do so but are thwarted from offering coverage because of costs.

The above "inherent" factors, coupled with the currently fractured marketplace, result in limited availability of health insurance for small business.

The Small Business Problem

The major underlying problem for small business is the cost of insurance and medical services. As described above,

some of the insurance costs are directly related to traits which are inherent in a small business. Rising health care costs, on the other hand, result from a non-competitive medical services marketplace. Still other small business costs are the direct result of changes that have occurred in the sale of insurance, changes which have forced carriers to respond in ways adverse to the interests of individual and small business purchasers.

To recap, the characteristics of smaller businesses that most significantly impact premiums, include the potential for adverse selection, the demographics of the small business work force, high turnover resulting in unpredictable participation rates, and a lack of expertise and clout in purchasing plans. Many of these factors drive up the carriers' administrative costs and make the small business community a less profitable marketing target.

Rapidly rising health care costs are driving the entire problem. Without medical cost containment, all mentioned solutions are simply short-term, temporary measures that will have little long-term impact. The medical inflation costs can be tackled through a combination of research, public information, education and enhanced consumerism. Health care providers and their patients must be educated to understand that more does not necessarily equal better, and expensive does not necessarily connote quality. Patients must be encouraged to question providers' fees and practices. Specific cost containment proposals are presented in NFIB's "Access for Small Business" strategy described later.

Increasing health insurance costs are also linked to the destruction of the industry's risk pool, induced by the passage of ERISA, which has forced almost 60% of the business community to self-insure to escape costly state regulation and taxes. The shrinking of the traditional insurance marketplace coupled with the trend toward reliance upon employer-based insurance has lead to new and aggressive underwriting practices for small firms.

Aggressive underwriting artificially raises premiums as insurers seek to protect themselves from all foreseeable, rather than potential, health risks. These practices have also institutionalized "churning," where insurers induce premature and frequent changes from carrier to carrier. This in turn leads to unforeseen adverse consequences. First, the preexisting condition clauses imposed on new customers can leave employees and owners without coverage for critical medical conditions. Second, each time a small business changes carriers in pursuit of lower premiums, it inadvertently raises the cost of the premium by increasing the carrier's administrative costs and by paying brokers' commissions. Third, frequent changes preclude the formation of small business associations or pooling mechanisms. And, fourth, this unstable marketplace means that insurers are unable to apply managed care concepts to the small group, thus leading to higher utilization costs.

All of these factors combine to make the small business marketplace volatile. This instability has resulted in higher premiums and lower coverage than the rest of the business community. This higher percentage of uninsured workers and owners is directly related to the high cost of insurance for small businesses.

The Solution -- "Access for Small Business" strategy

Attached as Appendix #2 is NFIB's broad outline for our "Access for Small Business" strategy. This strategy was explicitly created to accomplish the objective of ensuring that affordable insurance is available to small businesses and, by inference, to individual purchasers. It is essential that the solutions do not rely exclusively on employers and that the reforms promote the purchase of insurance by individuals and the formation of non-employment based purchasing groups.

The "Small Business Access" strategy; however, only brushes upon solutions for the other problems facing our society. A large part of the "health care crisis" remains untouched by the community but must be addressed in order to achieve significant improvement in the health status of all Americans. Health problems stemming from drug abuse, inner city violence, inadequate immunizations, etc. are outside the scope of NFIB's proposal, but should be an integral part of any successful health care reform effort. If they are not, our efforts will be viewed as a failure.

Small business owners desire to change the status quo, but prefer an incremental approach. They believe that current reliance on an employment-based system has worked. Since 1940, the number of people covered by health insurance coverage through their employer has increased from 40% to 84%. They also believe that this success can be built on and that coverage can be increased through a combination of incentives, a return to free market principles, and reforms of current law, that should be supplemented with a new reliance on non-employment-based insurance purchasing. Those changes, by their very nature, are incremental, but taken together represent a persuasive and comprehensive approach to ensure that a significant number of Americans are covered by health insurance.

The basis of the "Access for Small Business" strategy is two fold. The first prong consists of cost containment measures. The second suggests reforms designed to ensure the availability of affordable insurance. Both prongs must be addressed in tandem.

NFIB believes the problems facing small business in the health area are directly related to a dysfunctional market. Part of the NFIB incremental solution is to return competition

to these markets. Simply bringing predictability and competition to the marketplace will significantly drive down the cost of premiums. Further, reforms will help to reduce the cost of insurance packages even further and cost containment will control medical spending.

It is important, however, to understand the small business "definition" of insurance. Insurance is first and foremost a risk transfer mechanism. It is a necessary means by which one is protected from huge financial burdens, not simply a method by which to pay providers. Insurance is also a valuable fringe benefit. It is a means to attract and retain good workers, and it is a way to protect what is in effect the owner's extended family -- his/her employees.

Market Reforms and Incentives (21)

Several ways exist to reduce the impact of disproportionate administrative costs on smaller firms. It has been estimated that a large business receives 95 cents of benefits for every premium dollar. On the other hand, a small business receives only 65 to 75 cents for every dollar spent, thus 25 to 35% of its premiums are used to pay the administrative costs and profits of insurance companies. This administrative burden can be 20 times higher than that borne by a larger company. If the administrative costs alone could be reduced, the savings could be passed along to the small business. We can start that process by reducing the amount of paperwork flowing through the health care system. Streamlining and computerizing insurance and health delivery forms, including Medicare and Medicaid, will save thousands, if not millions of dollars. Further savings may be possible by eliminating the duplicate coverage that occur in home, auto, business and health policies.

* NFIB recommends the standardization of ratings practices. Small groups should be rated and charged premiums on the same basis as a larger business and should have the same predictability in premium increases. Through our surveys, NFIB has found that the inability to predict future premium costs keeps a great many small firms out of the insurance market and puts other firms on an expensive treadmill. NFIB believes that the practice by some aggressive insurers of arbitrary cancellation should be curbed. We also recommend the elimination of durational rating by restricting the ability of companies to lowball the initial premium through preexisting condition clauses.

* NFIB recommends that greater information be available to the consumer. Access to plain English information serves several purposes. First, it induces competition. Second, it aids small business owners (who themselves are the benefits managers and administrators) to be wiser, informed shoppers. Third, it aids in cost containment if the concept is boldly applied. And, finally, it instills accountability in the system and makes "deceptive" or aggressive ratings practices and defensive medicine less likely to occur. Further, NFIB

recommends publishing schedules of allowed or "usual and customary" charges for medical procedures.

* NFIB recommends that COBRA be reformed to reduce its impact on providing health insurance to current employees. Small business owners have expressed a very real concern that COBRA, in its present form and with its proposed expansions, is threatening insurance coverage. Based upon the numerous complaints NFIB has received, it is recommended expansions be opposed and reforms include:

1. Higher administrative fee: Studies indicate that the COBRA beneficiary greatly exceed the cost of the premium plus 2%. In fact, the average cost is in the neighborhood of an additional 51% with many beneficiaries costing the former employer a great deal more. While an increase may make the COBRA premium more expensive, it will go a long way to reducing the impact the COBRA costs have upon current employee's benefits. Not only is the business subsidizing the COBRA beneficiary's additional costs, so are the current employees' who many times share in the expense of premium increases. The COBRA Reform Coalition has even documented one situation where over 10 current employees and their families lost coverage because of the cost of one COBRA beneficiary. This is not a situation we would like seen repeated.
2. No third party reimbursement: It has come to our attention that many NFIB members receive COBRA premium checks not from the individual beneficiary but rather from the new employer, which many times is a competitor. This situation clearly defeats the transition purpose COBRA was intended to serve. This problem is a direct result of the ability of a former employee to stay with the COBRA plan until he/she decides to participate in the new employers plan, a decision which could be legally postponed until COBRA expires.
3. Shorter windows: The notice and "look back" requirements of COBRA are extremely burdensome on a smaller business. Many times an insurance carrier requires the employer to pay the COBRA premium to an election being made which results in a flow problem. Further, the "look back" provisions encourage adverse selection which have a serious impact on current employee premiums.

* NFIB recommends a level playing field so all employers have the same incentive to provide insurance. This includes the expansion of the tax deduction for the cost of health insurance for self-employed workers to 100%. The full 100%

deduction is a needed and obvious incentive to encourage expanded, voluntary provision of health insurance and would end the current tax code discrimination against the self-employed, partnership, S-corporation, sole proprietorship and farm owners. (22)

* NFIB recommends the establishment of a tax deduction or a tax credit for individuals for the cost of health insurance. This deduction, made available to non-itemizers, would provide an important and necessary subsidy for people to purchase health insurance on their own. A large part of the solution to this crisis is to recognize that individuals bear some responsibility for their own health care.

* NFIB recommends that cafeteria plans and flexible spending accounts be simplified in order to encourage their usage. These plans have several advantages. They allow employees to purchase care with pre tax dollars and permit the employer to have greater control over total benefit costs. Unfortunately, the complexity of the requirements, the "use or lose" and other financing provisions, coupled with the legislative uncertainty surrounding these devices make them unattractive to small businesses.

* The most important reform NFIB recommends is the across the board elimination of state mandates. The preemption of the 800-plus state health insurance mandates and state anti-managed care laws are essential to lowering the cost of health insurance. The state health insurance mandates -- ranging from herbal medicine care to invitro fertilization to chiropractic care to mental health care -- cumulatively can raise the cost of health insurance for small businesses and individuals by more than 30%. They also have a proven impact on increasing utilization and medical inflation.

The elimination of state health insurance mandates would enable "essential care" packages or standardized nationwide policies to be sold. These policies would be designed to be mass marketed, at a lower cost, to cover basic medical and catastrophic needs. NFIB data indicates that a lower cost plan would have great appeal to firms that currently do not offer health insurance coverage and to those that are struggling to make ends meet. Individuals would also be able to purchase this lower cost plan.

It is important, however, that the mandates be eliminated across the board. In order to have the ability to choose and design an insurance package, the mandates must be completely eliminated and not simply eliminated for a federally-determined "minimum benefit" package. This step is not without precedent. Already over 60% of the business community escapes the costly burden of state health mandates and taxes through self-insurance. This proposal simply provides the same treatment accorded larger firms be given to smaller ones.

Cost Containment Reforms

NFIB believes that reforms in other areas will not be successful until medical inflation is conquered at least brought under control. Attainment of significant cost containment must include, but should not be limited to, the following:

1. Consumerism. Patients must have information on provider fees, treatments and quality. Further, patients must share in the cost of those services. We should not fear the ability of patients to select and refuse treatments.
2. Data and guidelines. These include outcomes research, practice protocols, continuing medical education requirements, peer review, and publication of hospital outcomes.
3. Establishment of a uniform claims system for both private payers and the federal government. This is simply an extension of the Paperwork Reduction Act philosophy to the health field.
4. Wellness education and immunizations. The key to controlling future health care expenditures is to promote healthy behaviors and preventative care.
5. Medical malpractice reform. Reforms such as elimination of the collateral source rule, establishment of a uniform statute of limitations, caps on damages, as well as the use of practice guidelines as a defense would not only reduce malpractice premiums and doctors' fees but would curb the expensive practice of defensive medicine.(23)
6. Outreach to troubled populations. Private insurance cannot reach all Americans and cannot solve all of the health problems this country faces. Universal access is not possible without enhancing programs designed to reach these special populations. This can be done by reforming public health programs.
7. Tie a hospital's non-profit tax exempt status to the level of uncompensated care it provides. A very interesting GAO study indicates that many hospitals receive more in tax forgiveness than they provide in charity care. The original purpose of the tax exemption was to compensate a hospital for indigent care.
8. Reform the Medicaid and Medicare programs to reduce the impact these programs have upon the private sector and to ensure that limited funds are effectively spent

for quality care.

Counterproductive mechanisms

Any government policy that mandates small business owners to cover their employees will be accompanied by small business failures(24), changes in employment policies, higher unemployment and higher product costs to consumers(25). It also will mean an increase in the burden placed on public health programs. Small business owners overwhelmingly oppose mandated benefits(26), pay or play programs(27) and national health insurance(28). Beyond the philosophical opposition to mandates, there is the fear of the high uncontrollable costs it would impose. Most small firms cannot absorb the high cost and fluctuations in premiums that a mandated program would impose, nor can they afford to provide extensive benefits to workers who have little attachment to the work force(29). It is important to remember that many times when a firm does not provide health insurance as a fringe benefit or drops coverage, the owner and his or her family also loses coverage.

A pay or play program is opposed because it is a tax on labor. Already 37 to 50 cents of every dollar in compensation goes toward mandated programs such as workers compensation, unemployment insurance, Social Security, etc. This has had a significant impact on the growth in salary compensation. In fact, there has been no real growth in salary compensation for over six years, a fact mainly attributable to the growth in the tax burden borne by employees. Unfortunately, this runs counter to the desire of the employees who would prefer a wage increase to an increase in benefits,(30) putting small business owner/operators in the unenviable position of denying the former to comply with the latter.

Finally, small business workers oppose national health insurance systems. They remember the efficiency of the Post Office, the compassion of the IRS, the demeanor of OSHA inspectors and Pentagon prices. They have come to the conclusion that the private sector, for all of its problems, can deliver a higher quality and more efficient product than the federal government.

For a number of personal and business reasons the overwhelming majority -- almost 90% -- of America's small business owners want to provide health insurance for their employees. Unfortunately, because of run-away medical inflation, rapidly rising health insurance costs, and an inability to absorb either, they cannot provide coverage or are finding it difficult to continue to do so.

Conclusion

NFIB data collected over a decade clearly shows that cost is the main barrier to increased coverage and the primary cause of reduced benefits. The only solution is to stabilize health care and insurance costs. Medical inflation must be

brought under control and the health insurance market must be stabilized. Without both, the crisis will continue to grow.

NFIB has offered a significant numbers of suggestions for reform. There are others, and we continue to study those. The only options we rule out are national health insurance and mandated, employer-provided health insurance. NFIB believes that the current system has worked fairly well and needs to be adjusted, not replaced. We further believe that universal solutions will eventually make the U.S. health care system worse, not better. The best solution is one arrived at incrementally and one that builds upon the principles of the free market and quality affordable care and insurance.

Again, NFIB appreciates the opportunity to share with the Committee the data and conclusions we have accumulated over the course of more than a decade. Future surveys shall be shared with the Committee as the results become available.

HEALTH INSURANCE AND SMALL BUSINESS

The number one problem facing small businesses since 1983 remains the rising cost of health insurance.

The Dilemma: First, cost is a barrier to expanding coverage to the uninsured; second, rising costs threaten current coverage.

The Causes:

- A. Medical Inflation
- B. Government Intervention
 - 1. Cost shifting from the discounts "given" to the federal government and large businesses;
 - 2. Expensive state health insurance mandates;
 - 3. State anti-managed care laws that limit flexibility and cost savings;
 - 4. COBRA provisions which drive up premium cost for current employees; and
 - 5. ERISA law which distorts the health insurance market place.

The Small Business Situation: Two-thirds of small businesses offer health insurance as a fringe benefit. One-third have no insurance plan, with a majority of those citing cost as the reason for not offering insurance. Two out of three who currently are uninsured indicate that they would offer insurance if it was affordable. Further, 22% of the uninsured are self-employed workers.

* In 1990, almost 90% of small business owners indicated that it was becoming "prohibitively expensive" to provide health insurance to their employees.

The Small Business Problem: Increasing costs, coupled with problems finding affordable insurance.

- A. Some costs are inherent to small business, such as:
 - 1. Lack of expertise in designing and choosing plans;
 - 2. High employee turnover;
 - 3. Labor force demographics of the business;
 - 4. The higher probability of adverse selection; and
 - 5. Higher administrative costs -- an estimated 25-35% higher for small businesses.
- B. Others costs are related to changes in the marketplace, such as:
 - 1. Splitting and reducing risk pools through the prevalence of self-insurance;

2. Aggressive medical underwriting of small firms;
3. Forced compliance with state mandates and taxes by small, non-self insured businesses;
4. Churning which leads to the inability to apply managed care concepts to a small business; and
5. High medical inflation.

The Solution: Small businesses urge the adoption of an incremental approach to expand employment-based and individual coverage instead of the creation of a new bureaucratic process or program. There is also no political consensus for a universal approach. Incremental changes where consensus is possible can mean successful accomplishment of the goal of expanded coverage.

A. Cost Containment -- No long-term success can be achieved without tackling medical inflation and restoring competitive forces to the marketplace. First steps include:

1. Patient involvement in decision making;
2. Incentives for individuals to purchase insurance;
3. Outcomes research, guidelines and peer review; and
4. Publish mortality effectiveness and price data.

B. Small market reforms -- Some of the practices of carriers operating in the 250 employees or fewer market must be changed, and the law of large numbers must be reestablished. A beginning is to look to the proposals the industry itself has put forward. Some other reforms include:

1. Preempt, ~~across-the-board~~, state mandates and anti-managed care laws;
2. Permit the offering of an essential care package which provides affordable basic coverage; and
3. Prohibit aggressive insurer practices that encourage churning, increase administrative costs and force excessive underwriting.

C. Additional Measures

1. Enact 100% deductibility for the self-employed.
2. Pursue wellness education and incentives.
3. Undertake children's health initiatives.
4. Enact medical malpractice reform.
5. Reform the public health programs, including expansion of community health programs to address the crisis outside of the small business problem.

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

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END NOTES

- (1) A telling illustration of this is the increase in the number of uninsured self-employed business owners from 19% in 1989 to 22% in 1990.
- (2) The NFIB Foundation has conducted three comprehensive health surveys: 1978, 1986, and 1990. In addition, in 1983 and 1986, small business owners were asked to rank in order of importance 75 issues from liability insurance to garbage collection to taxes. Health insurance was ranked number one. Surprisingly, health insurance even ranked higher than liability insurance (ranked #2) at a time when the liability insurance crisis was at its peak (1986).
- (3) Two-thirds of small businesses offer health insurance. Between the first NFIB study (1978) and the second study (1986), the number of small firms offering health insurance increased by 8 percentage points. Between 1986 and 1990, the percentage of small firms declined by less than 2 percentage points. The decline may be within the range of statistical error or may be the indication of a trend. A 1990 follow-up field survey indicates the latter may be operating. These results were confirmed by the ICF study sponsored by the Small Business Administration.
- (4) "New" refers to both established and start-up firms. While two distinct groups, they share at least two common characteristics -- marginality and very limited cash flow. In addition, new firms have no past experience upon which insurance companies can assess the risk.
- (5) In 1990, over 89% of small business respondents cited the cost of health insurance as becoming "prohibitively expensive." In 1990, 19.7% of firms surveyed without health insurance indicated that health insurance was offered at some time in the past.
- (6) Between 1987 and 1990, small business health insurance premiums rose from an average of \$1,942 to an estimated \$3,192 [Foster & Higgins data].
- (7) Over 50% of the business community self insures, and that number has been rapidly increasing since ERISA's passage in the 1970s. Most firms that self insure tend to be large and profitable. Less than 49% of small firms are

able to self-insure. Self-insurance provides at least four benefits: 1) compliance with state mandates is not required, 2) no state premium taxes are assessed, 3) administrative costs are lower, and 4) the company has complete flexibility to design the health benefit plan.

- (8) There are over 700 state-mandated health insurance benefits requiring coverage for everything from chiropractic care to mental health care to in vitro fertilization to herbal medicine treatments. State health insurance mandates drive up the cost of health insurance for small firms between 20 to 30%. Larger businesses that can self-insure under ERISA are able to avoid these mandates and design their health plans according to their employees' needs, not as defined by the state government. In addition, state health insurance mandates have been shown to increase medical care inflation by creating an artificial demand for services. The Center for Policy Analysis (Dallas, Texas) estimates that 25% of the uninsured, both businesses and individuals, are the result of the higher costs created by state health insurance mandates.
- (9) SBA estimates that large firms receive 95¢ of benefits for every dollar in premiums spent, whereas smaller firms receive 60-75¢ of benefits for every dollar spent.
- (10) Sixty-one percent of the respondents in 1989 called for government help in reducing the cost of health care and health insurance. Small businesses also supported the imposition of doctor fee structures in Medicare. However, the majority of small firms oppose national health insurance and an overwhelming majority oppose mandates, strongly believing there are market-oriented "fixes".
- (11) Sixty-nine percent either agreed or strongly agreed that every American has the right to basic health care regardless of ability to pay, but they also believe that individuals have the primary responsibility.
- (12) Health insurance is the second most frequently offered benefits in a small firm. The first benefit offered is paid vacation time.
- (13) In today's shrinking labor market, small firms are intensely competing with both large and small businesses for qualified, skilled employees. A less generous fringe benefit package is a competitive disadvantage which neither attracts nor retains good employees.

- (14) The median small businesses owner takes out of his/her business less than the median wage and salary worker. About 40% of the 1989 study respondents took out of their business less than \$30,000 last year.
- (15) Small firms are price sensitive. Of those firms not offering health insurance, 28% said they would offer insurance if premium costs were lowered at least 20%.
- (16) To date, the employee-provided health insurance system has been successful. The number of Americans covered by employment-based insurance has risen from 40% in the 1940s to over 80% in 1988.
- (17) Small businesses typically engage in "one-stop shopping. One independent insurance agent is used to provide all of the business' insurance needs. In addition, there is limited expertise in the small business with respect to benefit design and negotiation. The owner is typically the benefits manager, payroll administer, etc. The average small business owner spends 8 to 10 hours a week on paperwork alone.
- (18) Small business owners view full-time employees (defined as working over 25 hours a week) as distinct from part-time employees. The limited connection to the workplace and the part-timers' preference for cash compensation or flex-time explain a difference between the benefits offered the two types of employees. This difference has been institutionalized by the insurance industry, which charges higher premiums for part-timers or refuses to cover such employees.
- (19) Less than one percent of those not offering health insurance stated that under no condition would health insurance be offered.
- (20) Less than 4% use HMOs or self insure.
- (21) NFIB currently has a follow-up survey in the field seeking to specifically identify insurance reforms beyond those mention in this section. The small businesses owners will be asked for their opinions on items such as guaranteed issue, community rating, tax preferences and risk pools.)
- (22) The implications of such an expansion are immense -- over 21% of self-employed workers are uninsured and 30% of these businesses employ one to four people. If the full deduction were restored, possibly one quarter to one half

of the working uninsured and their dependents could be helped. A full deduction provides a powerful financial incentive by reducing the cost of health insurance for perhaps the most expensive-to-cover portion of the business community.

- (23) The threat of malpractice claims is estimated to add \$4 billion to the cost of health care each year. It is also estimated that defensive action on the part of doctors costs \$100,000 per year per physician. (Source: Small Business Administration, 1991)
- (24) 12-26% surveyed indicated they would go out of business if the cost of the package was \$50.00 to \$150.00 per employee per month. (Small Business and Health Survey, NFIB Foundation)
- (25) Over 25-49% said they would change employment practices. 61% said they would raise prices if possible, 25% would eliminate part time jobs, and 31% would reduce other benefits. (Small Business and Health Survey, NFIB Foundation)
- (26) NFIB MANDATE vote: 89% oppose mandated health benefits (4% undecided, 7% favor). Full membership polled.
- (27) NFIB MANDATE vote: 94% oppose "pay or play" schemes (2% undecided, 4% favor). Full membership polled.
- (28) MANDATE vote: 78% oppose a national health insurance program (6% undecided, 16% favor). Full membership polled.
- (29) Small Business and Health Care, 1990 NFIB Foundation
- (30) Small Business and Health Care, 1990 NFIB Foundation

Further information may be obtained in the 1989/1990 "Small Business and Health Care" survey by the NFIB Foundation (Drs. Hall and Kuder). The survey was drawn on a random sample of 16,614 small business owners. Over 5,300 useable surveys were returned for a 29 percent response rate. A comparison of the estimated small employer universe and the survey respondents generally indicate that they are similar in size, industrial distribution, and geography (with a very slight western states bias).

APPENDIX 2
Access for Small Business Strategy

OBJECTIVE: To improve access to health care through affordable health insurance and cost-effective quality medical care.

I. Renewal of Federal Government Obligations

- A. Medicaid reforms
- B. Medicare reforms
- C. 100% deduction for the self-employed, sole proprietorship, partnership, and S-Corporation business owners (HR 784)

II. Removal of Government Barriers

- A. Pre-emption of state health insurance mandates
- B. Pre-emption of state managed care restrictions
- C. Simplification of cafeteria plans and METs
- D. Reinstatement of the individual line-item deduction for health insurance premiums.
- E. COBRA reform

III. Cost containment mechanisms

- A. Consumer information
- B. Outcomes research
- C. Physician practices guidelines
- D. Wellness education/preventive care promotion
- E. Medical malpractice reforms
- F. Living wills
- G. Coinsurance
- H. Hospital outcomes data

IV. Insurance Industry Preforms

- A. Return to the "law of large numbers"
- B. Underwriting reforms

V. Unacceptable Mechanisms

- A. Mandated benefits
- B. "Pay or Play" schemes
- C. Triggered mandates
- D. National health insurance

Chairman STARK. Thank you.
Mr. Weinstein.

**STATEMENT OF BARRY S. WEINSTEIN, BOARD PRESIDENT,
HEALTH CARE ACCOUNT PROJECT, CINCINNATI, OH**

Mr. WEINSTEIN. Thank you, Mr. Chairman. I am Barry Weinstein, executive vice president of Childrens' Hospital Medical Center in Cincinnati, OH. I appear before you today on behalf of the Health Care Account Project, which I will refer to as HCAP, our acronym, for which I serve as the board president.

HCAP is a not-for-profit organization funded by the State of Ohio for a 2-year period which will end this June 30 to conduct research and test an alternative health care benefit design. It is sponsored by the Chambers of Commerce, United Ways, and hospital associations of greater Cincinnati and Dayton. Each organization is represented on the project board as is Community Mutual Insurance Co., Ohio's largest Blue Cross and Blue Shield company.

Mr. Chairman, I hope my written testimony and attachments are helpful to you and your colleagues and staff, although in the limited time available I wish to highlight several of our project findings and reform recommendations.

The experience of this and other demonstration projects around the country bear careful consideration by policy makers. They highlight which alternative benefit design approaches can work and those that will not work in efforts to extend benefits to the uninsured workers and their families through our existing pluralistic system of financing health care.

Our experience and research, viewed along with that of other projects in other States indicate that primary care benefits are relatively inexpensive and have considerable market appeal.

Attached to my testimony is a research paper estimating the 1991 annual per capita cost of primary medical, preventive dental, and prescription drug services in this country as \$258, or approximately 15.8 percent, of the total per capita health spending by people under the age of 65.

Also attached is a review of several demonstration projects, about which you have heard today, with a primary care emphasis, including the Denver SCOPE project, which covered over 6,000 people in the first 18 months.

The four general conclusions we have reached from these experiences which speak directly to the provision of several proposals before Congress and a number of States are as follows.

First, the most basic of health care needs, primary care, is relatively inexpensive. However, most basic benefit plans included in major national reform proposals have deductibles of \$250 to \$500, effectively precluding most payment for these services. When one considers the low income levels of most uninsured workers and their families, these basic benefit plans are problematic. In effect, their deductible levels would force choice between seeking routine medical attention or paying for other basic necessities. Deductible levels in this range are more appropriate for those of us with moderate amounts of disposable family income. They are inappropriate for most of the uninsured workers.

Second, if first dollar or low out-of-pocket primary coverage is available, other cost-containment features are necessary. Our experience and market research in Cincinnati indicate one such option, high catastrophic deductibles of several thousand dollars, is simply not commercially viable. However, high coinsurance plans with rates as high as 50 percent, when combined with strong primary care benefits, offers a reasonable, comprehensive, and affordable option that has been successfully tested in the Denver SCOPE project. It is worth noting that a number of companies have introduced higher co-insurance plans in the small group market over the past year.

Third, for such alternative plans to reach significant numbers, reform of the small group market is necessary. Specifically, we are prepared to support State legislation requiring community rating of small group policies, limiting preexisting condition exclusions to one per lifetime for those who are continuously insured, creating a common reinsurance pool for all insurers operating in the small group market, and, like 24 other States to date, creating a State-supported risk pool for people with chronic conditions, which is indicated in your press release as being supported by yourself.

Finally, we have proposed to the U.S. Department of Treasury, and ask congressional support for, a change in the "use it or lose it" provision covering flexible spending accounts. In my written testimony, and attached Federal revenue impact analysis which meets Treasury guidelines, you will find outlined a proposal that will encourage low- and middle-income families to save pre-tax employer contributions for basic health care needs. Such savings would be treated for tax purposes as other employer-sponsored health benefits up to a reasonable ceiling. They would allow coverage of expenses for basic services, allowing flexibility for the tremendous variation in basic health care needs, while providing consumers incentives to exercise control over their utilization. This change would open a new, affordable alternative to small businesses and low-income workers, especially where combined with high coinsurance major medical plans mentioned earlier. Annual per enrollee Federal tax expenditures would amount to \$15 to \$23, a modest cost for an extension of benefits to uninsured workers that might result.

Mr. Chairman, I appreciate your attention. If you have any questions, I would be happy to respond. Or if I am not able to, I would be happy to have our project director follow up with you on a timely basis. Thank you.

[The prepared statement and attachments follow:]

Statement of the Health Care Account Project of Cincinnati, Ohio

INTRODUCTION

Mr. Chairman and members of the Subcommittee on Health, for the past two years, the Health Care Account Project (HCAP) of Cincinnati, Ohio has conducted research and conducted a demonstration project on options for extending private health insurance to uninsured workers in Southwestern Ohio. Jointly sponsored by the Chambers of Commerce, United Ways and Hospital Associations of Greater Cincinnati and Dayton, HCAP has been financed by a grant from the Ohio Department of Health for the purpose of developing and testing an alternative benefit design in the private market.

HCAP is one of a several organizations across the country that has tested alternative benefit designs over the past several years. The experiences of these projects, both successful and failed, can be of considerable value to public policy makers at the federal and state levels, in the consideration of measures to extend health care coverage to uninsured workers and their dependents.

In the late 1980s, spurred by the growing number of uninsured Americans, there emerged at the federal and state levels a wide range of proposals for reform of the health care system. Some of the proposals are broad and sweeping, such as the well-known Kennedy/Waxman and Pepper Commission plans. Others are incremental in nature, and include Medicaid expansion, mandated employer-sponsored coverage, publicly-subsidized but employer-sponsored benefits, and promotion of alternative benefit designs to extend "basic" health care services to the uninsured. Some have argued that incremental approaches do not offer long-term solutions for improving access or controlling costs. However, economic conditions, the federal deficit, competition for limited resources in the states, and resistance from numerous parties to radical modification of the nation's health care system, all contribute to the likelihood that reform initiatives in the near future will be incremental, with most implemented through the states.

An "alternative benefit design" may be simply defined as one that pays for services and offers utilization incentives differently than conventional commercial insurance or managed care plans. Research and experience from several demonstration projects around the United States support the conclusion that those which feature (1) low out-of-pocket primary and preventive care coverage; and (2) cost sharing for most complex and expensive services, offer the most appropriate and cost effective approach to expanding benefits and access through the workplace.

Several characteristics of uninsured workers, their employers and the insurance market are important to consider in evaluating this conclusion. First, the majority of uninsured workers and dependents have sub-poverty to lower-middle incomes, with a substantial majority under 200 percent of the poverty level. Second, the growth of the uninsured has been in large part due to the employment practices of small businesses, which supplied a significant number of new jobs created during the 1980s. In 1987, only 46 percent of the 2.8 million firms with under ten employees even offered health insurance, compared with virtually all firms with over 500 workers. Third, while the small business sector of the economy grew, the medical underwriting practices of commercial insurers, Blue Cross/Blue Shield plans and managed care organizations became increasingly stringent, especially in the small group market. Due to the virtual abandonment of community rating during the 1980s, the use of extensive medical histories for rating each small group, and the application of pre-existing condition exclusions to a mobile, relatively high-turnover workforce, many small businesses found obtaining or maintaining benefits to be impossible. And fourth, purchasers of health services, such as large employers with self-insured plans, insurance companies, and managed care organizations, began to implement cost containment policies such as selective contracting,

reducing the ability of providers to cost-shift uncompensated care to their plans. As a result, access for the uninsured that has been financed through this "back door" is being curtailed.

ALTERNATIVE BENEFIT DESIGN PROJECTS

Across the country, there are several alternative benefit designs being tested as parts of publicly and privately sponsored demonstration projects, or offered on the market through commercial initiatives. Two such projects, Denver's Shared Cost Option for Private Employers (SCOPE), and the Alabama Coalition for the Medically Uninsured project, have been supported through the Robert Wood Johnson Foundation's Health Care for the Uninsured Program. And in addition to the State of Ohio supported HCAP, Community Mutual Insurance Company (CMIC), Ohio's largest Blue Cross/Blue Shield organization, recently developed a unique small group product of its own.

Shared Cost Option for Private Employers (SCOPE)

The SCOPE product is a low-cost insurance plan which was first offered in the Denver area, but is now available in most of Colorado. It is sponsored by the Denver Department of Health and Hospitals and underwritten by New York based United States Life Insurance Company.

SCOPE covers a wide array of primary and preventive care services with no deductibles, requiring small copayments for office visits and prescriptions. It also covers catastrophic medical expenses, but requires subscribers to bear more of the cost for these services through coinsurance of 50 percent up to \$ 5,000. Care is provided through a limited provider network, enabling the plan to achieve significant provider discounts. Premium rates are approximately 50 percent less than traditional plans available to small businesses in the Denver area.

Central Alabama Coalition for the Medically Uninsured (BasicCare)

The Central Alabama Coalition for the Medically Uninsured is an initiative of the University of Alabama at Birmingham. BasicCare, the health plan developed by the coalition, is underwritten by Complete Health, Inc., the largest HMO in Alabama. It covers a limited schedule of benefits, focusing on primary and preventive care, with limited inpatient and outpatient hospital coverage. Preventive and primary care (such as routine check-ups, well child care, immunizations for children up to age five, hearing and vision screening) and office visits for illness or injury, are all covered, some visits requiring a small copayment. There is a 20 percent coinsurance requirement for inpatient physician and surgeon services, anesthesia, and ambulance services after the subscriber pays a \$ 100 deductible (one per individual and three per family).

A unique aspect of the plan is that it offers employers a choice of two delivery systems, through networks of either public or private providers. The benefits and cost-sharing are the same, but the premiums for the public option are about 40 percent less. Subscribers to the public plan may receive primary care services only at specified health clinics and must use the public hospital for all inpatient and outpatient care, or be referred to a participating hospital. The limited schedule of benefits and discounts from participating providers enable BasicCare to offer lower than average premium rates.

Health Care Account Project (PrimaryPlus)

PrimaryPlus is the insured health benefit designed by HCAP. It is underwritten by Community Mutual Insurance Company, which administers benefits in conjunction with a third party administrator, Benefit Administrators, Inc.

PrimaryPlus offers a unique combination of coverage, featuring a strong emphasis on primary care through an insured medical spending account. Routine primary and preventive care are covered without a deductible or copayment, up to an annual "cap." There is no pre-existing condition limitation for these services. This insured medical spending account is coupled with a high deductible catastrophic benefit, with deductible levels of either \$ 5,000 individual/\$ 10,000 family; or \$ 10,000 individual/\$20,000 family. After the deductible has been met, the plan pays 100 percent of eligible expenses.

At the end of each calendar year, for each employer group, 85 percent of the group's unused primary care medical spending account is carried forward and distributed equally among employees in the form of higher benefits, increasing coverage for the subsequent year. The plan also features a health credit assistance component to help plan members in obtaining no-interest loans to cover health expenses that are unpaid due to the higher than usual deductible levels. Premium rates for PrimaryPlus are comparable to the SCOPE plan. However, eligibility is restricted to employers that have not provided health benefits for at least 18 months.

Community Mutual Insurance Company (Low Cost)

Over the past year, health insurance companies have begun marketing high coinsurance "basic benefit" plans, designed to meet the small group market's demand for lower premiums, while providing broad coverage for major medical expenses. Many of these plans feature coinsurance rates of 50 percent, borrowing from the SCOPE project's success in Colorado. One such plan, developed in Southwestern Ohio by CMIC, pays 70 percent of the cost of covered services up to \$ 10,000, leaving 30 percent to the subscriber. Coverage is subject to an annual deductible of \$ 200 individual/\$ 400 family, and services must be accessed through a limited provider network.

Larger than customary coinsurance, at rates of 30 to 50 percent, is what characterizes CMIC's Low Cost and other similar commercial plans as "alternative benefit designs." They differ from the other three such designs described above, in that they virtually leave uncovered a number of primary and preventive health care services, through the use of high deductibles.

STRENGTH OF ALTERNATIVE BENEFIT DESIGNS

There are several advantages to alternative benefits as an incremental approach to solving the health care access crisis. First, they can be implemented within the existing pluralistic system of health care finance and delivery. Second, they rely on private sector initiatives to health care reform that require neither controversial mandates directed at employers to provide health coverage, nor increases in public spending. And third, the flexibility of alternative benefit designs can allow coverage to be tailored to meet the needs of subscribers, including primary and preventive health services.

SCOPE, BasicCare and PrimaryPlus encourage the use of primary and preventive services by limiting out-of-pocket expenditures for these services. In HCAP's PrimaryPlus, primary and preventive services are covered in full up to an annual cap of either \$ 175 or \$ 250 for individuals and \$ 500 or \$ 650 for families, depending on the plan option selected by the employer. BasicCare and SCOPE provide coverage for the same services with only small copayments.

By emphasizing the use of primary and preventive services, these plans decrease the need for more intensive and costly services. And by requiring subscribers to pay a substantial portion of the costs between the primary and catastrophic levels, they offer strong incentives for consumers and providers to contain unnecessary spending where utilization-driven cost increases are the greatest. In the same manner, they reduce premium costs to

levels that are more affordable for small businesses.

Importantly, these plans call attention to the fact that primary care is relatively inexpensive when compared to total per capita health care expenditures in the United States. Research conducted by the Health Care Account Project (offered as an exhibit with this testimony), estimated the annual per capita cost of primary care for persons under age 65 to be \$258 in 1991, or 15.8 percent of total personal health care expenditures. This figure represents the combined cost of a wide variety of services, including those provided by family practitioners, pediatricians, office-based internists, obstetricians/gynecologists, and general practitioners, together with the costs of preventive dental services and prescription drugs. Because this definition of primary care is so broad, it offers an estimate of the cost for a variety of typical basic family medical expenses without suggesting or prescribing a fixed combination of benefits.

POLICY IMPLICATIONS

A critical element in the design of any incremental health care reform package is the definition by policy makers of a "basic benefit" plan. The experiences of the four initiatives described in this testimony are valuable in that they demonstrate what can work, and what appears not to work, with regard to developing commercially viable "basic benefits." Specifically, they demonstrate (1) the desirability and relatively modest cost of primary care coverage; and (2) the acceptance in the market of higher than customary coinsurance for catastrophic coverage and, conversely, the rejection of high deductible plans.

With the exception of CMIC's Low Cost plan, the appeal of each of the alternative benefits derives largely from an emphasis on primary care coverage. SCOPE insured over 6,000 lives in its first 18 months on the market., while Alabama's BasicCare insured 300 lives in 50 firms during its first year. For PrimaryPlus, the main attraction to the plan has been its primary care coverage. However, it has suffered low enrollment as a result of its very high major medical deductible levels, as verified by extensive market research. Importantly, high out-of-pocket expenditures for major medical care have not posed such a barrier for two of the other plans, which instead incorporated high coinsurance (SCOPE's 50/50 and Low Cost's 70/30) above the primary care level. Both of these plans have shown considerable success in the market, their high coinsurance features serving as a model for a number of competitive products that have been recently introduced to the small group market nationally.

Taken together, the experience and research of these projects clearly show the cost effectiveness, competitive rates and market appeal of first dollar primary care coverage, when combined with higher than customary coinsurance for major medical expenses. In these features, they vary significantly from the "basic benefit" designs included in a number of widely known reform proposals. For example, the Kennedy/Waxman, Enthoven/Kronick, and Pepper Commission plans, to name but a few, feature traditional deductible levels of \$ 500, with no special provision for primary care. In effect, these proposals would maintain high out-of-pocket expenditures for primary health care services, while providing traditionally low coinsurance rates of 20 percent for catastrophic expenses. In view of the low incomes of most uninsured workers and their dependents, these "reforms" represent a tacit denial of access to the most basic and essential services. While appropriate for families with more discretionary income, they offer basic health care only at the cost of other basic necessities for most of the working uninsured.

If policy makers wish to promote market-based approaches using alternative benefit designs, they must make provision for benefits that best meet the needs of the uninsured, as discussed above.

Additionally, they must address regulatory and market problems which hinder efforts to meet the health insurance needs of small businesses. These include (1) various state mandates and federal IRS regulations which create barriers to alternative benefits; and (2) the insurance industry practices limiting coverage based upon pre-existing conditions and medical underwriting.

There are nearly 700 state mandated health benefits requiring reimbursement of certain types of providers, coverage of certain types of health services and categories of beneficiaries. Such mandates, and other regulations imposed by the states, together with federal exemptions for self-insured plans that are not a viable option for small employers, have priced insurance out of reach for as many as 9.3 million people, according to one estimate. Additionally, mandates preclude insurers from offering "no-frills" policies at reasonable prices. Under federal law, Medicare, self-insured companies, and plans for federal employees are exempt from state mandates. Thus, the full burden of mandates fall upon those most in need of low-cost products - the owners and employees of small business, the self-employed and unemployed.

Flexibility in developing alternative benefit designs to meet the needs of small businesses is also constrained by current federal regulations. While there is general familiarity with the discrimination against the self-employed in the tax treatment of medical benefits, other IRS regulations designed to prevent the use of flexible spending plans as tax shelters also pose a significant barrier to an alternative benefit initially designed by HCAP in Cincinnati. Specifically, Internal Revenue regulation 1.125-2 governing cafeteria plans and flexible spending accounts, includes a "use it or lose it" provision which denies pre-tax treatment for accumulated funds beyond the end of a plan year on an individual basis. Modification of the current regulations, in a manner that continues to preclude the unintended use of such plans to shelter large sums from taxation, would remove barriers to the use of employer-sponsored medical spending/savings accounts in alternative plans that emphasize primary care services, and encourage employee savings for future health care needs (see exhibit to this testimony which discusses such modifications, and its revenue implications in detail).

As noted above, small businesses are the least likely employers to offer health benefits to their employees. Yet, the practices of insurance companies have created myriad problems in the small group market for employers and, ironically, insurance companies themselves. The practice of assessing risk for each small group based on its members' medical histories denies the very purpose of insurance: to spread risk. In the market place, this medical underwriting has created a "vicious circle" in which an insurer that desires to include a large number of small firms in a community rated pool is almost certain to have adverse selection, so long as other insurance companies medically underwrite their own small group products. Additionally, it creates pressure on employers to exclude employees or dependents with high medical costs, thereby disrupting the workplace while creating a barrier to health care services for those who most need them.

After medical underwriting, the use of pre-existing condition exclusions presents the most significant problem for small businesses wanting to insure their employees. Virtually all insurers incorporate such exclusions in their small group policies. These generally provide that if an individual has been treated for a medical condition within a specified period of time before enrollment, payment will be disallowed for any care related to that condition for a period of time after enrollment, usually one year. This practice denies many benefits to people with chronic health problems, as well as millions of workers each year who change employers.

Consideration of these problems allows some generalizations

regarding the wider use of alternative benefit designs in incremental reform strategies. These include the following:

- "Basic Benefit" plans supported or suggested by federal or state legislation should include options which combine extensive coverage for primary care with higher than customary coinsurance for major medical expenses. Options should not be limited to high deductible plans typical of most major national "reform" initiatives. Primary care coverage through insured products, managed care programs or pre-tax medical spending/savings accounts should be encouraged in such plans (see below).
- State mandated benefits should be relaxed for qualifying "basic benefit" plans, as they are for self-insured plans.
- Internal revenue regulations precluding year to year, pre-tax savings for health care expenses in flexible spending accounts, should be modified to encourage savings for health care expenses, up to reasonable limits. Such accounts are especially appropriate for those of the uninsured with lower-incomes, and would be best used in combination with insurance policies that require coinsurance in the range of 30 to 50 percent (see exhibit detailing and providing revenue impact analysis on this proposal).
- Other internal revenue regulations should be modified to provide equal tax treatment of medical benefit costs to the self-employed.
- State-supported risk pools for people with chronic or other significant health care problems that make them "uninsurable," would benefit hundreds of thousands of Americans. While they would not significantly reduce the total number of uninsured, such actions would allow coverage and expand service access for some of the nation's most medically needy citizens, and reduce a portion of the adverse selection problem facing the small group market. To date, 24 states have created such risk pools.
- Regulation of the small group market is needed to alleviate problems confronting insurers and small employers. Requiring community rating of all policies sold in the small group market is necessary to stabilize prices, end the tremendous disruption these practices cause in the workplace, and equitably spread risk across larger numbers of employees. Such requirements would be enhanced if combined with the creation of common reinsurance pools for all insurers operating in the small group market. Such pools can equalize risk of large catastrophic claims, and the resulting losses that insurers can experience from adverse selection.
- Finally, pre-existing condition exclusions should be prohibited for people who have been "continuously insured," allowing for temporary interruptions beyond the control of the individual, such as layoffs, periods of unemployment, changes in marital status, and factors beyond the individual's control. Wherever such exclusions are applied, they should not extend for more than twelve months, and should apply at a maximum to conditions treated within the twelve months prior to enrollment.

Mr. Chairman, and Subcommittee members, there is considerable potential for using the experience and research of the alternative benefit design projects discussed in this statement in the

development of incremental health care reform strategies. Current insurance industry practices, as well as existing and certain proposed state and federal regulation of the structure, content and sales of insurance products, impose significant barriers to the development and application of their work. Carefully developed regulatory reform can remove these barriers, allowing roles for private initiative and the competitive market to expand health care access. While falling short of universal access and coverage, such incremental approaches are more realistic in the current economic, political and fiscal climate of the federal and state governments.

Thank you very much for the opportunity to offer this statement. We would be pleased to respond to any inquiries from you or your staff.

THE COST OF PRIMARY CARE

In the United States

An Estimate and Its Policy Implications

Submitted by:

John A. Begala, M.A., Sandra L. Kuehn, M.S., and Cathy Levine, M.A.

Skyrocketing health care costs, 20 percent per year premium increases for health insurance, 37 million uninsured Americans, are all symptoms of a health care system in crisis. Stemming the rise in health care costs, while increasing the number of Americans with health care coverage, is a complex and major undertaking. Several of the major proposals to address this issue (Kennedy-Waxman, Enthoven-Kronick, Massachusetts' Basic Health Plan, American Medical Association and the Pepper Commission) center on increasing the deductible and/or co-insurance levels for insurance plans, in effect increasing out-of-pocket expenses for health care.¹ Such approaches represent a tacit denial of access to basic services, especially for families with low to moderate incomes.

High deductibles and/or co-insurance levels for catastrophic care can be effective cost containment devices. However, these approaches should be coupled with first dollar coverage for primary and preventive care, encouraging the use of these services, in order to decrease the possible need for more intensive and costly services later. Such a strategy is relatively inexpensive. The Health Care Account Project (a research and development project funded by the State of Ohio and based in Cincinnati), estimates the annual cost of primary care at the beginning of 1991 to be \$258 per capita for Americans below the age of 65.

The \$258 primary care figure represents the combined cost for services provided by primary care physicians, including office-based Family Practitioners, General Practitioners, Internists, Pediatricians, Obstetricians/ Gynecologists, ² preventive dental care and prescription drugs. It is 15.8 % of the estimated 1991 per capita personal health care expenditure for the same population group. ³ This definition, because it is so broad and non-prescriptive, offers a means to estimate the costs for a variety of typical basic family medical expenses. Being a per capita estimate, it is important to note that the costs are spread over users and non-users of these health services and health care providers, and therefore does not adjust for non- or under-utilization by some individuals, or over-utilization by others. The estimate is limited further because: (1) it does not adjust for geographical variations in cost; (2) does not apply a deflator for portions of the selected physician specialties that are dedicated to non-primary care services; and (3) does not address the broader issues of "medical necessity" or efficacy. Known data sources do not readily allow adjusting for these factors and an exhaustive search of both published and unpublished national sources produced no existing research findings on the subject. However, anecdotal evidence suggests that such adjustments are likely to have an insignificant net effect.

As it stands, the estimate confirms what most health care providers and insurers already know: a wide array of primary care needs can be addressed for a relatively small fraction of the total per capita cost of health care in the United States.

METHODOLOGY

Data from the "personal health care expenditure" category of the National Health Care Expenditure report by the Health Care Finance Administration provides the base data for the calculation. The latest year for which national data are available is calendar 1988; however, calendar 1987 was used to be consistent with other data sources.

TABLE 1
PER CAPITA NON-AGED PERSONAL HEALTH CARE EXPENDITURE

CY 1987		
Category	Percent	Dollars
Hospital	44%	\$566
Nursing home	9	116
Physician services	23	296
Dental	7	90
Drugs/medical supplies	8	103
Eyeglasses/appliances	5	64
Other professional	4%	\$ 51
Total		\$1286

Source: "Health Expenditure by Age Group, 1977 and 1987," Health Care Financing Review, Summer, 1989.

These data indicate that in 1987 the non-aged per capita personal health care expenditure was \$1286. Of that amount 23 percent was spent on "physician services", 7 percent on "dental" and 8 percent on "drugs/medical supplies." ⁴

To separate primary care physician services from the broader category of "physician services" the number of office-based primary care physicians (as defined above) in 1987 was multiplied by the gross median earnings of each specialty. As calculated, thirty-three percent (33%) of the cost of "physician services" can be attributed to primary care physicians. ⁵ Based upon these calculations, 1987 primary care physician services were \$98 per capita.

TABLE 2

Per Capita Primary Care Estimate
by Service Category
1987

Primary Care Physician Services	\$ 98.00
Dental Care- Preventive and Restorative	42.00
Prescription Drugs	62.00
	<hr/> \$202.00

The "Dental" category of personal health care expenditure contains more than preventive dental care. Again, a national figure that separated preventive services from corrective dental services is not available from any known source. An analysis of dentists' time by type of service was obtained. It was determined that 77 percent of dental services can be attributed to general dental practitioners, who in turn spend 60 percent of their time in diagnostic and restorative services. ⁶ Based on these percentages, the 1987 per capita cost for preventive and restorative dental services was estimated to be \$42.00.

The category "drugs/medical supplies" accounted for \$103 of the total amount of per capita annual personal health care expenditures. According to personnel at the Health Care Finance Administration prescription drugs represented 60 percent of the total "drugs/medical" category in 1977, when their last study was done (no other published or unpublished sources on such expenditures are known). ⁷ Applying this figure to the 1987 per capita total yields an amount of \$62.00 for prescription drugs.

TABLE 3
ESTIMATE PRIMARY CARE EXPENSES
1987 - 1991

	Annual Primary Care Expense	Consumer Price Index for medical care services
	Dollars	Percent
1987	\$202	6.9
1988	216	8.6
1990	235	9.6
1991	258	

Source: Consumer Price Index, medical services from the U.S. Department of Labor Statistics

The total estimated per capita primary care cost of \$258 is derived by applying an adjustment for increases in the medical market basket since 1987 to the combined estimates for primary care physician services, preventive dental care and prescription drugs, as represented in Table 3.

CONCLUSION

Notwithstanding the limited applications of this estimate (noted above), it is clear that the combined cost of a wide variety of basic health care services is relatively modest. The implications of this conclusion are far-reaching, in that many major proposals focusing on the uninsured feature high deductibles and/or co-insurance to achieve cost savings; yet, the majority of the uninsured are low to moderate income workers. According to the Current Population Survey, 1987, three-fourths of uninsured workers earned less than \$10,000 and 34 percent earned less than the federal minimum wage.

Modifying consumer and provider behavior in order to achieve cost savings are the laudable goals of these proposed reforms. But given the economic status of the uninsured in America, for whom a trip to the doctor or dentist literally forces choices of eating, paying the utilities or covering other basic needs, these benefit designs are almost the opposite of what most people require:

coverage for basic health care services. High deductibles and co-pay arrangements will make a contribution to improving the health care system only where basic needs are covered. Alternative benefit designs currently being tested in Cincinnati, Denver and other sites, offer means of achieving both cost-saving incentives and coverage of most primary care needs.

TABLE 4

NON ELDERLY POPULATION WITHOUT HEALTH INSURANCE
BY FAMILY INCOME, 1986

Family Income	Number of Uninsured	Percent of Uninsured
Under \$10,000	12.5 million	33.8%
\$10,000- 19,000	10.4 million	28.2%
\$20,000- 29,000	5.6 million	15.2%
\$30,000 or more	8.4 million	22.8%

Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey, from "Uninsured in the United States: The Nonelderly Population without Health Insurance, 1986," Deborah Chollet, Ph.D. Employee Benefit Research Institute, October 1988.

NOTES

1. a. Under the Kennedy-Waxman proposals, "Basic Health Benefits for All Americans Act," employers must enroll all employees working at least 25 hours a week in a health plan, and offer coverage to those working between 17.5 and 25 hours. Employers would pay at least 80 percent of the premium for full-time workers. The bill specifies the basic minimum plan to include medically necessary inpatient and outpatient hospital and physician care, diagnostic and screening tests, prenatal and well-baby care, and some mental health care. There would be limits on the deductibles paid by the employee and plans would include a catastrophic cap on out-of-pocket costs for covered services. Coverage could not be denied due to preexisting conditions.
- b. The Consumer-Choice Health Plan for the 1990's, proposed by Alain Enthoven and Richard Kronick, would require employers to cover all full-time employees and their dependents, and would be required to pay an 8 percent payroll tax on the first \$22,500 of all other employees not covered (i.e. part-time). All full-time workers (working at least 25 hours a week) would be offered a choice of qualified plans. A qualified plan would have to include a basic benefits package specified in the HMO Act. Deductibles could be no higher than \$250 per person, in 1988 dollars, (approximately the current cost of primary care) adjusted for inflation. Total out-of-pocket expenditures for deductibles and coinsurance for contracting providers' services could not exceed 100 percent of the annual premium.
- c. The Massachusetts health care law, (Ch. 23), viewed by many to be a model for other states, provides for increased access to health insurance through mandated employer-sponsored health insurance as well as insurance for the unemployed through a tax on employers. The law sets up a basic benefit plan, The Direct Coverage Plan, for the unemployed who either were not insured at their previous job or who had medical coverage while working and now pay the premium themselves. The Direct Coverage Plan enables the recipient to have: 100% coverage for prenatal and well baby care; coverage for physician office visits with a \$25 per visit co-payment after meeting a \$50 deductible; \$300 deductible for all other covered ambulatory services including 50% co-pay on hospital outpatient services, \$10 co-pay on prescriptions; 30% co-pay on all other ambulatory services; \$1200 inpatient hospital deductible, and 80% of covered inpatient charges are paid after the deductible is met. The application of these complex deductibles and co-payments to primary care services, again, are contrary to the most basic health needs of the vast majority.
- d. The Pepper Commission specified a benefit package that includes preventive services, such as prenatal care, well-child care, mammogram, pap smears. Deductibles are set at \$250 for an individual and \$500 for a family. Coinsurance is 20% for all services except prenatal care, well-child care, mammogram and pap smears, which have no co-insurance. The maximum a family or person would pay out-of-pocket is \$3,000 a year.

NOTES (continued)

2. "Physician services" expenditures estimates, as defined by the Health Care Financing Administration, include spending for services received through offices of physicians or osteopathic physicians, spending for independent medical laboratory charges that are billed directly by the lab to the consumer and benefits provided by salaried physicians in health maintenance organizations.
3. The \$1286 for 1987 is from the "Health Expenditure by Age Group, 1977 and 1987, Health Care Finance Review, Summer, 1989. The subsequent years expenditure is an estimate calculated by applying the medical price index to the previous years personal health care expenditure.

ESTIMATED PERSONAL HEALTH CARE EXPENDITURE
PER CAPITA, NON AGED POPULATION
1988-1990

	Dollars	Medical services index, percent
1987		
1988	\$1286	6.9
1989	\$1375	8.6
1990	\$1493	9.6
1991	\$1636	

Source: Consumer Price Index, medical services from the U.S. Department of Labor Statistics

4. Percentages are taken from the reported "personal health care expenditure" and are applied to the "non-aged personal health care expenditures" in the absence of percentages specific to the non-aged group.

NOTES (continued)

5. National data do not break out General Practitioners from Family Practitioners. There is a significant difference in the gross median earnings between the two specialties; therefore, a breakdown of the nationally reported category "General Practice" was calculated based on information in "Doctor's Earnings: On the Rise Again," Arthur Owens, Medical Economics, September 7, 1987.

To calculate the percentage of "physician services" provided by primary care physicians the total gross median earnings for all primary care physicians (\$29,503,059,600) was calculated as a percentage of the total gross receipts from all office-based physicians (\$90,461,515,000) reported by the Census Bureau, Census of Service Industries for 1987. Primary care physicians' gross earnings were 33 percent of all physician services.

This percentage (33%) was applied to the (\$296) per capita cost of physician services to conclude that \$98 of the \$296 was for primary care physician services, in 1987.

Office-based Primary Care Physicians

Gross Median Earnings 1987			
Specialty	Number of physicians	Gross median earnings per specialty	Total gross earnings per specialty
Family Practice	32,460	\$185,000	\$6,005,100,000
General Practice	21,640	146,390	3,138,679,600
Internal Medicine	52,500	183,420	9,629,550,000
Obstetrics/ Gynecology	23,600	290,790	6,862,644,000
Pediatrics	22,600	\$171,110	\$3,867,086,000
Total	152,800		\$29,503,059,600

Source: Statistical Abstract of the United States, 1989, Table 150, "Physicians, By Type of Practice: 1970 to 1986."

Income data from Medical Economics, September 5, 1988, p. 161.

6. Published data on preventive dental care was not located. The analysis of preventive, restorative and corrective dental services was supplied by staff at the Bureau of Economic Behavioral Research, from data from the Distribution of Dentist's in the U.S. by Region and State, 1987.

NOTES (continued)

7. According to staff at the Health Care Financing Administration, the last time a study was conducted to separate prescription drugs from "drugs/medical supplies" was in 1977. This study found that 60 percent of the expenditures for this category was for prescription drugs. In the absence of more recent data this percentage was applied to the total expenditure category "drugs/medical supplies".

**Projected Impact on Federal Revenues
Resulting from Certain Proposals
Designed to Promote Health Insurance Coverage
for Employees of Small Businesses**

**Prepared for
The Health Care Account Project**

**Coopers
& Lybrand**

Certified Public Accountants

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**Projected Impact on Federal Revenues
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Designed to Promote Health Insurance Coverage
for Employees of Small Businesses**

March 13, 1991

I. Summary and Conclusions

Under current regulations governing flexible spending accounts (FSAs), unexpended funds remaining in FSAs at year's end must be forfeited by the employee. The Health Care Account Project (HCAP) has proposed that these regulations be modified to permit employers offering catastrophic health insurance to their workers to roll over funds which they contribute to their employees' medical FSAs. HCAP believes that this change would encourage many small businesses, which presently do not offer insurance, to begin offering such coverage. To limit the opportunities the change may afford some taxpayers to shield excessive amounts of income in FSAs, the proposed regulations would also restrict the amounts that may be carried over from one year to the next to twice the annual out-of-pocket maximum for the catastrophic insurance and would contain significant measures to discourage employers and employees from expanding existing tax-favored health care benefits.

Table 1 shows the impact the HCAP proposal would have on federal revenues over the fiscal year period, 1991 to 1996. This projection relates only to employees currently uninsured who would respond to the incentive to participate in a FSA. Based on the underlying assumptions of the revenue projection model constructed to determine these effects, federal payroll and income tax revenues for this group would decline by about

\$1 million in 1991, the first year of the regulatory change. By 1996, the revenue drop would equal \$11 million -- about \$23 per participating employee. This loss can be traced to two factors: (a) About one-half million currently uninsured employees would participate in FSAs; and (b) The amounts that these employees and their families would spend annually on health care would increase.

The HCAP proposal could conceivably also provide employees currently participating in FSAs (or considering do so) with an incentive to have their employers fund contributions which would qualify for a rollover. A provision in the proposal, however, would limit a firm's overall health care benefits per employee in the first year a rollover was offered to the previous year's level. In combination with the recent rule requiring that an employee's maximum contribution amount be available during an entire year of coverage, this additional limitation would deter participation, at least during the revenue projection period; consequently, we have not included revenue effects for participation by these employees.

Even in the absence of this constraining provision, however, we believe that any resulting revenue losses would likely be offset by reduced employer funding of other health-related tax benefits, since employers will generally seek to restrain overall health care expenditures. Thus, an increase in spending on FSAs which is not balanced by a decline in other employer-funded health expenditures is unlikely. Nonetheless, for completeness we have provided in an Appendix to this report an order of magnitude for the potential decline in revenue that some may argue could occur.

Table 1
Summary of Revenue Projections Resulting Under HCAP Proposal

Fiscal Year	1991	1992	1993	1994	1995	1996
Revenue Loss from Currently Uninsured Employees (\$ Millions)	0.5	1	3	5	8	11
Participating Uninsured Employees (Millions)	0.04	0.1	0.2	0.3	0.4	0.5

II. Background

Significant differences exist in the extent to which firms of different sizes offer health insurance to their workers. Numerous studies have been conducted which conclude that smaller firms are less likely to offer their employees such coverage.¹ A number of factors have been identified as responsible for this lower rate of coverage. Among them are that:

- smaller firms have fewer numbers of employees over which to spread insurance risk;
- because smaller firms also have a proportionally larger share of seasonal and part-time employees which are administratively more expensive for insurance providers to manage, they also face higher loading factors;² and
- tax benefits for health insurance are primarily directed towards larger companies which employ most workers.

Recently, efforts have been made to encourage or compel small businesses to offer insurance coverage to their employees. In Massachusetts, for example, a provision was considered which would have levied fees for health care on businesses which do not provide coverage. Similar federal legislation was introduced in the last Congress (e.g. H.R.1845, "The Basic Health Benefits for All Americans Act"). In addition, numerous experimental programs and insurance policies have been conceived in order to determine

¹ See for example, "Health Care Coverage and Costs in Small and Large Businesses," U.S. Small Business Administration, 1987; "Uninsured in the United States: The Nonelderly Population without Health Insurance, 1986", Employee Benefit Research Institute, 1988; "National Medical Expenditure Survey: A Profile of Uninsured Americans -- Research Findings 1," Department of Health and Human Services, September 1989; and "The Economics of Health Insurance Offerings by Small Firms," Alan Monheit and Pamela Farley Short, October 1989.

² Unloaded premiums are an accurate reflection of the cost of medical expenses per employee. The load typically applied to small business is 40 percent (versus 2.5-5.0 percent for larger firms) which accounts in part for the lower coverage rate among small firms.

how best to promote coverage based on economic incentives.³ The Health Care Account Project (HCAP), supported by grants from the Ohio State Department of Health, is one such program designed to promote innovative ways to reduce the number of uninsured workers.

III. The HCAP Proposal

To foster increased financial support for health expenses incurred by small business employees, HCAP has advanced the idea of encouraging employers not offering insurance to their workers to establish flexible spending accounts (FSAs) which would allocate a fixed amount of money to cover employee medical expenses.

Current Treasury regulations requires that funds contained in FSAs in excess of reimbursable medical expenses at the end of a year must be forfeited by employees. The excess amounts generally may be neither converted into taxable income nor rolled over to be applied against future expenses. HCAP seeks to change the latter rule with regard to employer contributions to FSAs to permit their use for medical expenses, irrespective of when the monies may have been initially contributed. To qualify for this change, FSAs would be required to have the following five characteristics:⁴

- (1) The FSA must be offered together with a commercial insurance policy (or equivalent benefit, such as an HMO), which provides catastrophic health insurance coverage. Such coverage would take effect for annual medical expenses over some specified level (depending on deductible amounts, coinsurance, or both).
- (2) Each year, the employer must contribute a specified amount to each FSA for single employees and for employees with families. Employees could also be allowed to

³ The Alpha Center for Health Planning in Washington, D.C. is currently conducting 12 experiments in different metropolitan areas under a grant from the Robert Wood Johnson Foundation. The results of these studies, referred to collectively as the Health Care for the Uninsured Program (HCUP) projects, are being analyzed by economists at the University of Michigan School of Public Health.

⁴ The HCAP proposal refers to these qualifying FSAs as Medical Spending Accounts (MSAs), but for simplicity's sake, this report will continue to refer to these accounts also as FSAs.

contribute to the FSA on a pre-tax basis, although employers might wish to restrict such contributions in order to limit additional liability that could result when employees with outstanding medical expenses quit before the end of the year.

- (3) Amounts in the FSA attributable to employer contributions that are not used to reimburse medical expenses in any year could be carried over to the next year, provided that if an employer contributed to any form of health care benefits during the twelve months prior to the first plan year for which the employer adopts such a FSA, the average annualized per-employee amount of tax-favored health care benefits does not increase during the first plan year.
- (4) Amounts in the FSA attributable to employee pre-tax contributions are not eligible for carryover treatment. (To the extent a FSA contains both pre-tax employee and employer contributions, medical expenses would be reimbursed first from the pre-tax employee contributions.)
- (5) The amount carried over from one year to the next could not exceed twice the annual out-of-pocket maximum for the catastrophic insurance. This restriction would preclude the possibility that rollovers may serve as a means for permanently deferring ever greater amounts of income.

The HCAP proposal is designed to provide employers a cost-effective way to offer health care benefits to employees, many of whom are currently receiving no employer-provided health care coverage. The carryover provision of the proposal creates an incentive for employees and their dependents to be prudent purchasers of health care services. Economic studies indicate that if FSA funds cannot be carried over from year to year, employees and dependents have no incentive to restrict their annual health care utilization below the total amount in the FSA. This can lead to unnecessary spending and contributes to health care inflation.⁵

⁵ See, for example, "A Study of Cafeteria Plans and Flexible Spending Accounts," U.S. Department of Health and Human Services, 1985, Chapter II.

IV. Discussion of Current Tax Treatment of FSAs

Under current law, § 125 of the Internal Revenue Code (IRC) permits compensation arrangements under which employees may exchange various types of nontaxable benefits for taxable cash and under which these nontaxable benefits can be paid for on a before-tax basis.⁶ The original justification for FSAs was couched in terms of IRC § 125, because a FSA offered employees a choice between taxable income and a non-taxable fringe benefit.

Nonetheless, the tax treatment afforded the HCAP proposal under current laws and regulations is somewhat uncertain. The proposed FSA would apparently fall within the definition of a health flexible spending arrangement (FSA) provided in Proposed Treasury Regulation § 1.125-2, Q&A-7(c). Under this definition, a FSA is "a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) ..." These regulations set forth the rules that must be satisfied in order for the employer-provided health coverage provided through a health FSA to qualify for the exclusion from income under Internal Revenue Code § 106 and for the health FSA reimbursements to qualify for the income exclusion under § 105.

Under the Treasury's proposed regulations, health FSAs are subject to a rule that provides that the maximum amount of reimbursement must be available at all times during the period of coverage, regardless of the amount of contributions that have been made to the FSA at any point in time. Furthermore, health FSAs are subject to a "use-it-or-lose-it" rule under which employees must either use the amount available in their FSAs or forfeit it at the end of each year. Generally, unused FSA amounts may not be paid to the employee or credited to his or her FSA for the subsequent year.

⁶ For additional discussion, see "A Study of Cafeteria Plans and Flexible Spending Accounts", Appendix 1.

The proposed regulation would appear to prohibit that aspect of the HCAP proposal which would allow unused amounts to be carried over from year to year. However, Revenue Procedure 91-3 creates some uncertainty about the tax treatment of carried over amounts, at least with respect to reimbursement accounts funded solely by employer contributions. Among the topics discussed in the revenue procedure are areas in which the Internal Revenue Service will not provide private letter rulings because they are under extensive study. One of the areas under extensive study is:

[§ 5.05] § 105 - Amounts Received Under Accident and Health Plans - Whether a medical reimbursement plan, funded by employer contributions, containing a provision allowing unused amounts to be carried over and accumulated in an employee's account qualifies as an accident and health plan under § 105.

This suggests that the IRS has not finally decided how it should treat programs such as that proposed by HCAP. However, for purposes of this revenue projection, it is assumed that the FSA modification proposed by HCAP must satisfy the rules set forth in the proposed regulations under § 125.

V. The Revenue Model

To determine the effect on federal tax revenues of the HCAP proposal, a revenue projection model has been constructed. The model incorporates the type of assumptions the Treasury Department normally adopts to project such changes and is designed to produce results similar to those that would be obtained by the Treasury and the Congressional Joint Committee on Taxation (JCT) when estimating the revenue consequences of a change in the rules pertaining to FSAs.⁷

The model focuses on changes to individual income and Social Security tax revenues over the period, fiscal years 1991-1996 (October 1990 through September 1996). It

⁷ Coopers & Lybrand has benefitted from discussions with government revenue estimators.

assumes that the HCAP proposal, if adopted effective January 1, 1991, would induce additional tax-free contributions to employees' FSAs in lieu of taxable income, and thus affect both income and payroll tax revenues. Consistent with the methodology generally used by the Treasury, though, it assumes that any benefits from a FSA change would accrue solely to workers and that overall employer compensation costs would remain unchanged. Reduced employer expenses from substituting tax-free fringe benefits for taxable cash income could be offset either by changes in employment or by higher total compensation per employee.

As a consequence, business income taxes (corporate and non-corporate) are projected to be unaffected by the proposed change. The benefits of the shift to tax-free FSA income are reflected instead as lower individual income taxes and payroll tax contributions. With regard to payroll taxes, it is assumed that the benefits of both the lower employee and employer shares of the tax accrue to the workers, although the employer's share is reduced to reflect the fact that it is a deductible business expense.

Central to the revenue projections shown in Table 1 are certain key assumptions. These assumptions and the sensitivity of the projections to changes in these assumptions are discussed below:

Population of Qualifying Employees. An important factor in determining the revenue effects of the HCAP proposal is the number of employees likely to be offered participation in a FSA. Because the proposed change is directed primarily towards small businesses, we focus on the number of uncovered workers in firms with fewer than 100 employees. Larger employers may also not provide insurance, but we assume that there are structural reasons for their failure to provide coverage (e.g. personnel are seasonal hires), which this proposal does not address. We expect, however, that some employers currently offering FSAs to their employees (or considering doing so) may substitute employer-funded contributions for currently offered health insurance benefits as a way of reducing overall

health care costs. We assume that these firms' ability to do so, though, will be limited.⁸

In discussing the potential revenue changes resulting from the proposal, we will distinguish between the changes related to small employers that presently do not offer insurance and those related to large employers already offering FSAs.

⁸ We assume that the proposed change will induce employers with health insurance to shift from existing coverage only if it reduces their out-of-pocket expenses. In the past, the introduction of (employee-funded) FSAs to which employees contributed either were costless to employers or resulted in direct savings. (From the Treasury's perspective, though, FSAs may have expanded tax revenue losses as individuals pay for health care expenditures from pre-tax dollars. See "A Study of Cafeteria Plans and Flexible Spending Accounts.")

To understand the factors limiting the widespread adoption of employer-funded FSA contributions, consider the following typical family policy: Health care expenses amounting to \$2000 annually; employer-provided insurance consisting of a \$250 deductible amount and requiring that 20 percent of charges above the deductible be paid by the insured family. The employee incurs \$600 of out-of-pocket expenses, on average, and contributes \$600 to an FSA. If employer contributions to the FSA were eligible for rollover, the general arrangement of fringe benefits might change. The employer would contribute no more than the amount currently paid for employees' coverage -- \$1400 (including premium charges). As an example, the employer could contribute \$400 to the FSA and the remaining \$1000 (\$1,400 less \$400) to cover premium charges. Either employees would pay a larger share of the remaining premium charges for the insurance policy, or the policy would be revised to raise the deductible amount (Option #1) or the coinsurance rate (Option #2) or both. The net effect in this instance would be to provide employees with first-dollar coverage up to the employer's FSA contribution. In the long run, however, the change could bring about a reduction in employer-provided benefits if FSA contributions are not automatically indexed to rise with the cost of health care.

	<u>Current Law</u>	<u>Option #1</u>	<u>Option #2</u>
Plan Characteristics:			
Plan Expenses	\$2,000	\$2,000	\$2,000
Deductible Amount	250	750	250
Coinsurance Rate	20%	20%	43%
Covered Expenses/Premium Charges	1,400	1,000	1,000
Out-of-pocket Expenses	600	1,000	1,000
FSA Contribution:			
Employee	600	600	600
Employer	--	400	400
Total	600	1,000	1,000

The example above also illustrates why the proposal's tax impact for employees already participating in FSAs is likely to be small -- increased revenue losses from FSAs will be offset by reductions in other tax-favored benefits.

Number of Qualifying Employees: Our figures are based on tabulations from the 1989 March Current Population Survey (CPS) which has been supplemented with questions regarding the health insurance coverage of survey respondents.⁹ Table 2 presents unpublished tabulations from the Department of Health and Human Services (HHS) based on 1989 data.¹⁰ Panel A shows estimates of the numbers of uninsured workers aged 18 to 64 by size of firm.¹¹ Roughly half of all such workers are employed in firms with fewer than 25 employees.

Panel B displays the information in terms of labor force attachment. Research by health policy experts indicates that an important factor contributing to non-coverage is the lack of a permanent full-time job.¹² Employment in seasonal occupations, such as construction and retail trade, for example, is often linked with the absence of insurance. Based on the CPS tabulations, roughly half of all uninsured workers are employed less than full-time full-year.¹³

⁹ The March CPS questionnaire contains an insurance supplement each year directed to the U.S. noninstitutionalized population. The content of the insurance segment was revised in 1987, however, making it difficult to compare more recent data with previous survey results. Studies examining the demographic and socioeconomic characteristics of the insured based on these data include "Uninsured in the United States: The Nonelderly Population without Health Insurance, 1986," Employee Benefit Research Institute, October 1988.

¹⁰ Figures from the CPS contained in Table 2 were provided by G. Moyer in HHS. Several other surveys have examined the uninsured population and have drawn different conclusions concerning both the number of uninsured and the general time trend regarding the size of the population. The National Medical Expenditure Survey (NMES) and the CPS both reported between 36-37 million uninsured in 1987, although the CPS projected the number of uninsured to be growing annually somewhat faster (3.7 percent versus 3.4 percent). The Survey of Income and Program Participation (SIPP) estimated a smaller number of uninsured in 1988 (31 million) and an annual decline in the population of roughly 2.5 percent.

¹¹ Workers 65 and above are generally covered by Medicare. Those below age 18, if insured, generally are covered by a parent's insurance.

¹² See, for example, "The Economics of Health Insurance Offerings by Small Firms."

¹³ According to the CPS definitions, workers employed fewer than 50 weeks are treated as part-year employees and those working fewer than 18 hours per week are treated as part-time.

Table 2

Derivation of the Number of Uninsured Employees Qualifying Under Proposal

Panel A

(Uninsured Workers by Size of Firm)

Firm Size:	1-24	25-99	100-499	500-999	1000+	Total
# (Millions)	8.6	2.8	2.0	0.7	3.6	17.8

Panel B

(Uninsured Workers by Labor Force Attachment)

Labor Force Attachment	Full time Full year	Part time Full year	Full time Part year	Part time Part year	Total
# (Millions)	8.5	1.4	5.6	2.3	17.8
Share	47.8%	7.9%	31.5%	12.9%	100.0%

Panel C

(Crosstabulation of Uninsured Workers by Size of Firm and by Labor Force Attachment)

Firm Size (# Employees)	Full time Full year	Part time Full year	Full time Part year	Part time Part year	Total
1-24	4.1	0.7	2.7	1.1	8.6
25-99	1.3	0.2	0.9	0.4	2.8
100-499	1.0	0.2	0.6	0.3	2.0
500-999	0.3	0.1	0.2	0.1	0.7
1000+	1.7	0.3	1.1	0.5	3.6
Total	8.5	1.4	5.6	2.3	17.8

Source: Current Population Survey, Department of Health and Human Services tabulations.

Panel C contains a cross-tabulation of uninsured workers displayed by firm size and by labor force attachment in order to determine the number of small business full-time full-year employees that could be affected by the HCAP proposal. This tabulation assumes that employment in different size firms and job tenure are uncorrelated with one another. Thus, employees of both small and large firms are assumed to be equally likely to work full-time full-year. Because it is difficult to validate this assumption, it is conservatively assumed that all employees of firms with fewer than 100 workers who work full-time full-year qualify for the HCAP proposal (darkly shaded area of Panel C), and that, additionally, half of those who work either part-year or part-time (but not both part-year and part-time) also qualify (lightly shaded area of Panel C). This adjustment increases the projected number of qualifying workers from 5.4 million (full-time full-year employees) by another 40 percent to 7.7 million.¹⁴

Growth of Uninsured Employees. There are few sources of data which measure changes to the uninsured number of employees over time. Many surveys are conducted on an occasional basis and the CPS, which elicits such information annually in its March survey, has altered its questionnaire format, thereby complicating comparisons between different periods. The Health Interview Survey conducted by the National Center for Health Statistics, though, has measured changes to the uninsured over time. Based on its sample, the number of uninsured employees grew between 1984 and 1989 from 12.7 million to 16.2 million at an annual growth rate of 5.0 percent. We assume that this rate of growth will continue throughout the projection period, 1991-1996. Applying this rate to the number of qualifying workers obtained from the CPS (7.7 million) results in a projected 8.5 million

¹⁴ Industry analysts note that the employer typically has considerable discretion in establishing a cutoff level for participation in plans like FSAs. Typical criteria for establishing eligibility are full-year employment and employment for 30 hours per week or more; the law, however, requires coverage (if offered) only for those employed a minimum of 35 hours per week. A Hewitt Associates report entitled "Flexible Compensation Programs and Practices, 1989" provides evidence which is consistent with our assumptions: About one-third of employers Hewitt surveyed offered plans to part-time employees working 20 hours or more per week, but another third excluded such workers entirely from coverage (see Tables 5 and 6).

qualifying employees who lack insurance and who are employed by small businesses in 1991.

Participation rates. The projection of 8.5 million workers assumes that employees of all kinds of firms would participate without regard to the legal form of the business. The benefits from a FSA can accrue to employees of regular corporations, partnerships, proprietorships, and S-corporations, but not to partners, proprietors, or shareholders in S-corporations.¹⁵ Data from the 1982 Censuses of Industry stratify employees by the legal form of their employer. Table 3 shows that, although corporations make up less than half of all enterprises, they employ over 80 percent of workers recorded.¹⁶ Although we believe that most other forms of enterprises will not participate when their owners are unable to benefit directly, we assume conservatively that all regular corporation employees and half of the employees of other enterprises could potentially have FSAs -- altogether 89 percent of the 8.5 million workers.

We next consider the rate at which small business employers would offer FSAs. A study underway by the Alpha Center for Health Planning suggests that participation rates among employers currently without insurance are likely to be fairly low. Roughly 80 percent of all small businesses with between 25 and 100 employees that were surveyed in four metropolitan areas claimed to already provide coverage; employers with fewer than 25 employees participated at a rate of about 50 percent. Overall, the share of small businesses offering insurance was 60 percent.

¹⁵ Economic theory suggests that competition among firms ensures that all workers with similar skills and experience receive equal compensation, irrespective of the kind of business employing them. The anecdotal evidence relied on here, however, implies that factors other than a worker's "human capital" -- for example, differences in work environments or differences in legal form of business -- may cause differences in compensation among similarly qualified individuals. A more thorough discussion of apparently inexplicable wage variation appears in "Anomalies: Interindustry Wage Differentials," Richard Thaler, Journal of Economic Perspectives, Spring 1989, pp. 181-193.

¹⁶ Because the Census data do not distinguish between regular and S-corporations, an adjustment is made to the corporate share based on the share that S-corporations comprise of all corporate taxable returns filed in 1982 -- about 20 percent based on the IRS Statistics of Income. Assuming that, on average, S-corporations employ a fewer number of workers per firm than do regular corporations but the same number as do partnerships, the share of regular corporation employees qualifying for an FSA is about 78 percent.

Table 3

Derivation of Share of Qualifying Employees Likely to Participate Under Proposal

Legal Form of Enterprise	#	Employees	Employees/ Enterprise	Share of Employees
Corporations	1,944	50,999	26.2	82.7%
Individual Proprietorships	1,898	7,315	3.9	11.9%
Partnerships	365	2,711	7.4	4.4%
Other	<u>49</u>	<u>635</u>	<u>13.0</u>	<u>1.0%</u>
Total	4,256	61,660	14.5	100.0%

Adjustment for regular corporations:

	Regular Corporations	S Corporations	Total	Regular Corporation Share
Taxable Returns	1,608	395	2,004	80.3%

Apportionment of employees, assuming S-corporations resemble partnerships:

	#	Employees	Employees/ Enterprise	Share of Employees of Corporations
Regular Corporations	1,561	48,154	30.8	94.4%
S Corporations	<u>383</u>	<u>2,845</u>	<u>7.4</u>	<u>5.6%</u>
Total Corporations	1,944	50,999	26.2	100.0%

Note: Employees of regular corporations as a share of all qualifying employees -- 78.1% (i.e. 82.7% x 94.4%)

Source: 1982 Census Enterprise data, IRS Statistics of Income

The Alpha Center promoted insurance plans designed to attract those firms currently without coverage. Anecdotal evidence indicates that the response to these products, though, was well under 10 percent.¹⁷ Applying a 10 percent share to the number of qualifying employees reduces potential participating employees in 1991 to 0.8 million (i.e. 8.5 million x 89 percent x 10 percent). By 1996, this figure is projected to climb to 1.0 million.

FSA Contributions per Employee. Industry analysts report information on the market penetration of employee fringe reports including FSAs for medical expenditures. The most recent data for 1989 indicate that FSA contributions averaged about \$670 per employee, about \$100 higher than in 1988.¹⁸ The distribution of these contributions is bi-modal reflecting the fact that singles and employees with families have different expenditure patterns (see Figure 1). The modal range for singles is between \$200 and \$400 annually and for those with families between \$600 and \$1,000.

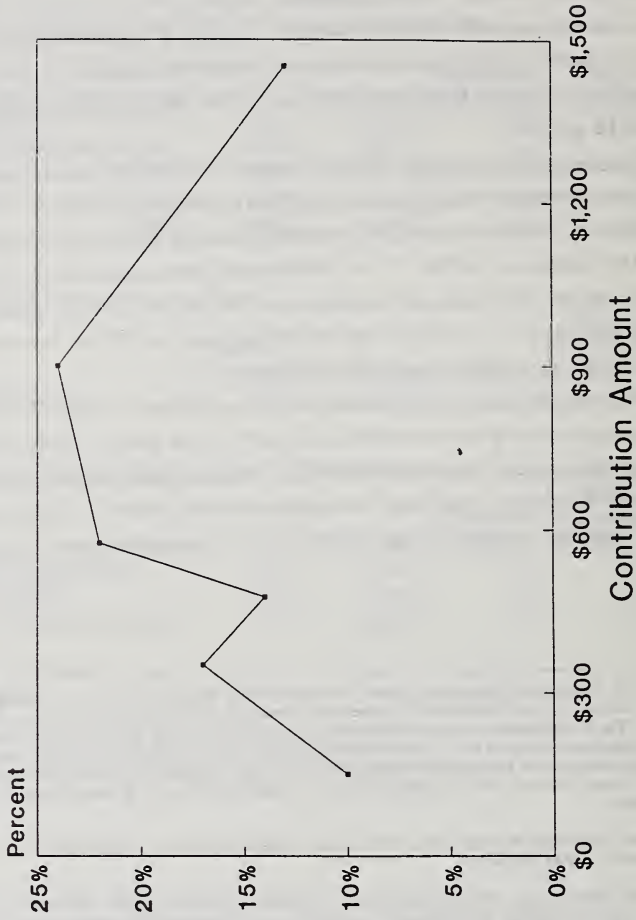
Industry observers note that FSA contributions generally involve salary reduction and that employers currently do not contribute to FSAs.¹⁹ In the absence of hard evidence regarding likely employer behavior under the HCAP proposal, though, we rely on available information to establish a range within which contribution levels may fall. HCAP promotes several insurance products in the Cincinnati-Dayton metropolitan area, the more

¹⁷ This information is based on an as-yet unpublished study being performed at the University of Michigan School of Public Health of HCUP experiments conducted in Tucson, Tampa, Denver, and Flint, Michigan. The kind of insurance typically offered differs from that proposed by HCAP, however. Generally, the plans resembled the typical Blue Cross/Blue Shield package -- a \$100-\$250 deductible, 20% copayment, catastrophic coverage, and exclusions for mental illness and drug dependency. Unlike the general industry practice, though, (but much like the population HCAP is targeting) half to all of premiums were paid by the employer.

¹⁸ See "Health Care Benefits Survey, 1989: Flexible Benefit Programs," A. Foster Higgins & Co. Inc., 1990, Tables of Survey Responses.

¹⁹ The Hewitt report "Flexible Compensation Programs and Practices, 1989" indicates that twenty percent of employers offering the "stand-alone" type of FSA -- an FSA which is furnished separately and is not part of a more comprehensive fringe benefit package -- provided an employer contribution. The report does not contain information, however, on the annual amounts these employers contributed.

Figure 1
Distribution of FSA Contribution Amounts



Foster Higgins 1989 Health Care Survey

comprehensive of which currently cost about \$850 for single employees and \$2,100 for those with families.²⁰

By comparison, the Health Insurance Association of America (HIAA) in its most recent analysis of insurance practices reports that, for 1989, insurance policies cost employers, on average, about \$1,200 for singles and \$2,400 for those with family coverage.²¹ Recognizing that the HIAA's figures reflect 1989 costs which have since risen and that employers first purchasing insurance will be unlikely to accept costs exceeding those incurred by firms currently insuring their employees, we assume that employer contributions to FSAs under the proposal would be about \$250 per single employee and \$500 per employee with family. (Typically, health benefits provided to families are somewhat less generous than those provided to singles on a per capita basis.) Overall, the average contribution would amount to \$400 in 1991.

Estimates of employer-paid insurance premiums by the Health Care Financing Administration (HCFA) lend support to these projections. Employer payments of premiums amounted to \$128.8 billion in 1989, or about \$1,919 per employee. Informed projections of the rise in premiums between 1989 and 1991 by HHS increase this figure to over \$2,300, roughly comparable with the HIAA amounts.²²

Growth of FSA Contribution Amounts. Although health care expenditures are likely to grow at an inflation rate higher than for the economy as a whole, it is assumed that in an effort to control overall labor costs, employers will strive to have FSA contributions grow at a more modest rate. We assume a growth rate for contribution amounts patterned after the most recent forecast of the Consumer Price Index (lagged one year) reported by the

²⁰ These options include an annual primary care benefit ranging between \$175-250 per single individual and \$500-650 per family, and a catastrophic expense ceiling of \$5000 per individual and \$10,000 per family.

²¹ See description of 1989 HIAA Employer Survey results in "Employer-Sponsored Health Insurance, 1989," Gabel, DiCarlo et al., Health Affairs, Fall 1990, Exhibit 7.

²² HCFA estimates are derived from unpublished projections of the Office of National Cost Estimates which classify overall health expenditures by type of payer. HHS inflation projections for unloaded insurance premiums are 11.1 percent for both 1990 and 1991.

Congressional Budget Office. The general range of these increases is between 4 and 5 percent annually. Table 4 shows these inflation rates and the corresponding FSA contribution levels assumed for each year of the projection period. The amounts rise from \$400 in 1991 to \$483 in 1996.

Table 4
Projected Growth in Employer-funded FSA Contributions

Calendar Year	1991	1992	1993	1994	1995	1996
Contribution Amount	\$400	420	434	450	466	483
CPI-U	4.9%	3.5%	3.6%	3.6%	3.6%	N/A

Source: "The Economic and Budget Outlook," Congressional Budget Office, Table I-4.

Induced Health Expenditures Caused by FSAs. The availability of health insurance and FSAs triggered by the proposal is likely to induce additional spending on medical expenditures by currently uninsured employees and their families. We conservatively rely on an estimate by HHS of the increase in tax expenditures due to the introduction of refundable FSAs among insured employees -- 63.5 percent.²³

Amounts Rolled Over Annually in FSAs. The revenue cost of the HCAP proposal results from the ability to roll over unexpended funds in specific employees' accounts to the future years without tax consequences, and any inducement to participate in FSAs that this tax

²³ See "A Study of Cafeteria Plans and Flexible Spending Accounts," Table 3. The table contains estimates of tax expenditures relating to three prototype insurance plans characterized by different degrees of cost sharing. Our analysis is based on Plan B, the median plan, which contains a \$150 deductible for single individuals (\$300 for families), and 15 percent coinsurance. Out-of-pocket expenses under Plan B amount to 32 percent of total health care expenses.

The HHS figure is higher still than a 46 percent increase predicted by the Rand Health Insurance Experiment for a change in coverage from free health care to 95 percent coinsurance. See "Health Insurance and the Demand for Medical Care: Evidence from A Randomized Experiment," Manning, Newhouse et al., American Economic Review, June 1987, Table 3.

change might provide. To determine the share of FSA contributions that would not be spent in one year, we rely on information on the share of FSA contributions which have been forfeited by workers in firms with 1,000 or more employees. For 1989, this figure fell to 5.3 percent from the previous year's level of 6.1 percent.²⁴

We conservatively assume that modification of the forfeiture requirement will result in less concern about the accuracy of the amounts initially placed in FSAs and, consequently, increase the potential share rolled over to 10 percent. One could argue, however, that this share may well be lower, since, under the proposal, employer contributions to FSAs for currently uninsured workers are not assumed to be as large as employee contributions under present law. If lower-income workers and their families are also in poorer health than the general population, it is also less likely that they will be able to defer medical expenditures and thereby accumulate surpluses in their FSAs.

Market Penetration/Learning Curve. Because of the difficulty marketing to small businesses poses, we assume that the share of eligible employers and employees that will take advantage of the proposal will grow slowly over the projection period. We project that initially only 5 percent of those qualifying will participate. This share will grow to 10 percent in the following year and then increase an additional 10 percent each year until in 1996 a 50 percent share is achieved.

Employees' Marginal Tax Rates. As noted earlier, the HCAP proposal will affect both individual income and Social Security taxes. To project the impact on tax revenues from the extension of a rollover provision to FSAs, it is necessary to determine the tax rate applicable to each source of revenue.

Payroll tax rate -- For payroll taxes, which are proportional for wage income below the Social Security wage ceiling (\$51,300 in 1990), the tax rate paid by employers

²⁴ See "Health Care Benefits Survey, 1989: Flexible Benefit Programs."

and employees is 7.65 percent. Because payroll taxes are a deductible business expense, the true rate paid by (fully taxable) employers after income taxes is 5.05 percent and the combined employer-employee payroll tax rate equals 12.7 percent. It is assumed that this combined rate is the payroll tax rate applicable to each dollar of cash income shifted into a FSA.²⁵

Income tax rate -- The average marginal income tax rate faced by uninsured workers is more difficult to determine because publicly available income tax data do not contain information identifying the characteristics of a taxpayer's employer or of his insurance coverage. The tax rate is projected instead by reference to tabulations from the 1987 National Medical Expenditure Survey (NMES) and from the IRS Statistics of Income publication (SOI). Table 5 presents the relevant information.

Panel A shows, based on the NMES, that roughly half of all uninsured households in which a member is employed by a small business are married. Panel B indicates that, compared to insured workers, uninsured workers' wages are about one-third lower.²⁶ The average hourly wage was almost \$8 or, on an annual basis, about \$17,500 per worker.

Panel C presents additional information from the 1985 SOI concerning the share of joint returns filed claiming the two-earner deduction. Although these data do not identify whether an employer is a small firm, based on these figures, about half of all couples filing benefitted from the deduction. For lower incomes, though,

²⁵ If firms without insurance are less profitable, the combined payroll tax rate could be greater, since less of the tax would be a deductible business expense. We have not adjusted for this consideration, because in the discussion which follows we have compared the shares of revenue due to payroll and income tax sources and found that the payroll tax share is high -- 44 percent -- relative to those from government projections for other tax-favored fringe benefits.

²⁶ Independent information from "Health Care Coverage and Costs in Small and Large Businesses," Small Business Administration, 1987 (see Table C-3: Percentage of Employees by Salary and Firm Size) and from "Health Insurance Coverage: A Profile of the Uninsured in Selected States," U.S. General Accounting Office, February 1991 (see Table V.1: Low-Income Families Have Higher Uninsured Rates in the 15 States) confirm this result.

Table 5
Derivation of Average Marginal Income Tax Rate Faced by Participating Employees

Panel A
(Share of Uninsured Employees Who Are Married)

	1-9	10-25	26-100
Married	6.3	3.5	3.3
Never Married	4.5	4.0	2.8
Widowed, Separate Filers	1.9	0.9	0.8
Total	12.7	8.4	6.8

Married as share of Total: 49.6% 41.8% 48.1%

Panel B
(Relative Wages of Uninsured Employees)

Hourly Wage	Total Employment	Size of Firm			Total Uninsured	Size of Firm		
		1-9	10-25	26-100		1-9	10-25	26-100
Less than \$5	26.7%	41.2%	35.4%	26.5%	55.0%	53.9%	58.0%	53.5%
\$5 to \$10	39.5%	39.5%	40.1%	39.7%	32.3%	33.6%	30.6%	32.0%
Greater than \$10	33.8%	19.3%	24.5%	33.8%	12.7%	12.5%	11.4%	14.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Average Wage: \$11.32 \$9.07 \$9.90 \$11.33 \$7.76 \$7.49 \$8.02
 --relative to Total: --- 80% 87% 100% 68.5% 66.1% 70.9%
 Average Wage for Insured Employees: \$12.70 \$11.18 \$12.66
 --relative to Insured: 61.1% 69.6% 62.9% 63.4%

Source: National Medical Expenditure Survey

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this share is lower -- about 15 percent for those with under \$10,000 and under 40 percent for those with incomes between \$10,000 and \$20,000. Assuming that deductions comprise 20 percent of (adjusted gross) income for these taxpayers, about 5 percent are not taxable, 60 percent face the 15 percent tax rate, and 35 percent are in the 28 percent tax bracket.

Panel D integrates the information described in the preceding panels in order to determine the composite income tax rate. Roughly half of uninsured workers are married and roughly half of all joint filers have two wage earners -- these workers are likely to have higher family incomes than all other uninsured employees and their overall marginal tax rate is almost 19 percent (see first set of columns in Panel D). This percent is adjusted to reflect the lower pay scale common to small firms and the fact that the uninsured often are paid less, too. The second set of columns shows that, based on these modifications, the tax rate for uninsured two-earner couples drops to 16 percent.

The third and fourth set of columns present similar information for married one-earner couples and for single employees. Their tax rates are projected to be about 12 percent and 18 percent, respectively. (It is assumed that uninsured singles generally do not itemize.) Combining these results, the composite income tax rate for all uninsured workers is 15.9 percent.

The total tax rate -- payroll tax and income tax -- faced by uninsured employees is thus 28.6 percent of which payroll taxes comprise 44 percent. Comparing the relative levels of the payroll tax and income tax shares with other available information, the Congressional Budget Office reports that for a reduction in health insurance tax benefits, about 34 percent would be related to payroll taxes.²⁷ The relatively larger share

²⁷ See Option ENT-17: Tax Employer-Paid Health Insurance, Reducing the Deficit: Spending and Revenue Options, Congressional Budget Office, February 1990, p.144.

attributable to payroll taxes in this projection, though, is reasonable given the generally lower salaries paid to uninsured workers and those employed by small businesses.²⁸

Employees of Firms Offering FSAs

Number of Qualifying Employees. According to the proposal, to qualify for the rollover of FSA contributions, firms must also offer their employees health insurance satisfying certain minimum qualifications. Projections from the NMES show that, in 1987, 66.3 million employees were already insured -- about 65 percent of total employment. Because, absent other stipulations, the number of insured employees that could potentially benefit from the proposal would be relatively large compared to the number of uninsured employees for whom the inducement is intended, the HCAP proposal additionally requires that employers currently offering insurance who opt for the proposal must also limit their employees' average annualized amount of tax-favored health care benefits during the first year the proposed benefit is offered to the previous year's amount, without any adjustment for inflation. We have not prepared an explicit projection of the revenue consequences of this provision, but it would appear that it should discourage adoption of the benefit by those seeking to expand tax-favored health benefits, and, at the same time, prompt employers to consider rollovers only in instances when they may be seeking an opportunity to review their overall policy regarding firm-sponsored health benefits. In the Appendix, we discuss the revenue effect the HCAP proposal could have if this requirement were not included.

²⁸ Indeed, tabulations from the 1986 CPS performed by the Employee Benefit Research Institute indicate that of 16.5 million uninsured workers between ages 18 and 64, about three-fourths reported incomes below \$10,000 and another 20 percent had incomes between \$10,000 and \$20,000. Even assuming that those in the lowest income group have an average marginal income tax rate of 10 percent, those in the next group face a rate of 15 percent and all others have a rate of 28 percent, the overall rate would be 12.1 percent. Recognizing that CPS respondents often understate their incomes and that the Census definition of income is not fully comparable with income reported for tax purposes, the assumed rate of 15.9 percent appears reasonable.

VI. Detailed Discussion of Projections

We outline below the specific computations performed to project the changes in federal revenue resulting from modification of the current rules regarding employer contributions to FSAs. Projected revenue changes for the budget period, 1991-1996, are the sum of federal payroll tax and income tax liabilities, each of which is discussed separately below.

Payroll Tax Liability for Employees of Firms without Insurance (Table 6). To project tax liability, it is necessary to determine first the number of Participating Employees without any insurance. Total Uninsured Employees are projected to equal 8.5 million individuals in 1991. Only 7.5 million are likely to be ever offered insurance (and FSAs) by their employers -- those employed by regular corporations and half of remaining employees (90 percent of 8.5 million). Of this number, only 10 percent are likely to participate, or 0.8 million (10 percent of 7.5 million).

If firms were to begin offering their employees insurance and FSAs immediately and if employees were to rush to participate, the Payroll Tax Liability in the first year of the projection period, 1991, would equal the product of the following terms:

- the Number of Participating Employees (0.8 million);
- the Payroll Tax Rate (12.7 percent);
- the Contribution Amount per Employee (\$400); and
- the Share of FSA Contributions Rolled Over (10 percent); increased by
- the Additional Expenditures due to the Introduction of FSAs (63.5 percent).

The result of these computations equals \$7 million. We assume that the Market Penetration Rate in the first year is 5 percent; thus, the first year's Payroll Tax Liability equals \$0.3 million.

In subsequent years, the Number of Participating Employees and the Contribution Amount per Employee will rise. The Number of Participating Employees will grow at a

Table 6
Change in Payroll and Income Tax Liability for Currently Uninsured Employees Under Proposal

Calendar Year	1991	1992	1993	1994	1995	1996
Total Uninsured Employees (Millions)	8.5	8.9	9.3	9.8	10.3	10.8
Employees Offered FSAs (Millions)	7.5	7.9	8.3	8.7	9.2	9.6
Participating Employees (Millions)	0.8	0.8	0.8	0.9	0.9	1.0
Contribution Amount Per Employee	\$400	\$420	\$434	\$450	\$466	\$483
CPI-U	4.9%	3.5%	3.6%	3.6%	3.6%	3.6%
Increase Induced by FSAs	63.5%	63.5%	63.5%	63.5%	63.5%	63.5%
Share of FSA Funds Rolled Over	10%	10%	10%	10%	10%	10%
Penetration/Learning Curve	5%	10%	20%	30%	40%	50%
Payroll Tax Rate	12.7%	12.7%	12.7%	12.7%	12.7%	12.7%
Payroll Tax Liability:						
Year						
1	0.3	0.03	0.003	0.0003	0.00003	0.000003
2		0.7	0.07	0.007	0.0007	0.00007
3			2	0.2	0.02	0.002
4				2	0.2	0.02
5					4	0.4
6						5
Total	0.3	1.0	2.0	3.0	4.0	5.0
Payroll Tax (\$ Millions)						
Income Tax Rate	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%
Income Tax Liability:						
Year						
1	0.4	0.04	0.004	0.0004	0.00004	0.000004
2		0.9	0.1	0.01	0.001	0.0001
3			2	0.2	0.02	0.002
4				3	0.3	0.03
5					4	0.4
6						6
Total	0.4	1.0	2.0	3.0	5.0	7.0
Income Tax (\$ Millions)						

rate of 5 percent (from 0.8 million in 1991 to 1.0 million in 1996), and Contribution Amounts will rise at the inflation rate (lagged one year) from \$400 to \$483. The Market Penetration Rate will also climb from 5 percent in the first year to 10 percent in the second year, and then by an additional 10 percent each year thereafter. (In 1996, the Penetration Rate will equal 50 percent.) The Payroll Tax Rate, the Additional Expenditures due to the Introduction of FSAs, and the Share of FSA Contributions Rolled Over are assumed to remain unchanged over the projection period, however.

The Payroll Tax Liability in subsequent years, 1992-1996, then equals the sums of several products:

First,

- the Number of Participating Employees;
- the Payroll Tax Rate (12.7 percent);
- the Contribution Amount per Employee (\$420 in the second year);
- the Share of FSA Contributions Rolled Over (10 percent); and
- the Market Penetration Rate (10 percent in the second year); increased by
- the Additional Expenditures due to the Introduction of FSAs (63.5 percent).

And, in addition,

- the Number of Participating Employees in previous years;
- the Payroll Tax Rate (12.7 percent);
- the Amounts Previously Rolled Over from past years (\$40 in the second year -- 10 percent of the first year's contribution, \$400; \$46 in the third year, representing 10 percent of \$420, plus \$4 -- 10 percent of the first year's rollover from the second year, \$40);
- the Share of FSA Contributions Rolled Over (10 percent); and
- the Market Penetration Rate (10 percent); increased by
- the Additional Expenditures due to the Introduction of FSAs (63.5 percent).²⁹

²⁹ In the following example, we examine under the proposal the extent to which funds in an FSA that are rolled over may grow as a share of annual contributions, even without assuming an explicit change in taxpayers' behavior. In the example, we assume an initial contribution of \$1000 to an FSA which rises each

Income Tax Liability for Employees of Firms without Insurance. Income Tax Liability is projected in a manner similar to that applied for Payroll Tax Liability. The Income Tax Liability in the first year of the projection period equals the product of:

year at the rate of inflation -- 5 percent in the first two years and then a huge 20 percent in the third and fourth years. Proceeding with our assumption that 10 percent of each year's contribution is rolled over, the amounts rolled over in the FSA grow in nominal terms from \$100 in the first year to \$173.21.

A clearer understanding of how the rollover share is changing can be ascertained by restating the amounts rolled over each year in "real" terms, adjusted for inflation. After adjustment, the amount rolled over in the second year equals \$109.52. This is equivalent to an increase in the rollover rate from 10 percent to 10.952 percent. In the following year the rate increases again, but by only a slight amount to 11.043 percent. If the rate of inflation were to remain constant, the rate change in the next year would equal a fraction of this year's increase.

We examine, however, the impact of a rapid rise in inflation in the next two years to 20 percent per year. The higher rate of inflation reduces the value of existing amounts in the FSA, and, thereby, also reduces the implicit rollover rate from 11.043 percent to 10.92 percent. The effect of the change in inflation also quickly fades, though, and the impact of another year's worth of 20 percent inflation is to reduce the rollover rate by one one-hundredth of a percent. Thus, the net effect of changes due to inflation and to the buildup of funds rolled over is relatively small.

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5</u>
Contribution Amount	\$1,000.00	\$1,050.00	\$1,102.50	\$1,323.00	\$1,587.60
10% Rollover:					
Year 1	100.00	10.00	1.00	0.10	0.01
Year 2		105.00	10.50	1.05	0.11
Year 3			110.25	11.03	1.10
Year 4				132.30	13.23
Year 5					158.76
Total	100.00	115.00	121.75	144.48	173.21
Increase in Contribution Amount due to Price Inflation	---	5%	5%	20%	20%
Restatement of Rollover Amounts in Real Terms:					
Year 1	100.00	9.52	0.91	0.08	0.01
Year 2		100.00	9.52	0.79	0.07
Year 3			100.00	8.33	0.69
Year 4				100.00	8.33
Year 5					100.00
Total	100.00	109.52	110.43	109.20	109.10
Rate of Increase	---	9.5%	0.8%	-1.1%	-0.1%

- the Number of Participating Employees (0.8 million);
- the Income Tax Rate (15.9 percent);
- the Contribution Amount per Employee (\$400);
- the Share of FSA Contributions Rolled Over (10 percent); and
- the Market Penetration Rate (5 percent in the first year); increased by
- the Additional Expenditures due to the Introduction of FSAs (63.5 percent).

The result of these computations equals an Income Tax Liability of \$0.4 million.

The Income Tax Liability in subsequent years is also calculated in the same way as the Payroll Tax. Income Tax Liability each year equals the sum of several components: The Income Tax Liability for the particular year and the Income Tax Liability due to amounts rolled over and traceable to previous years. As with the Payroll Tax Rate, the Income Tax Rate is assumed to remain unchanged over the projection period.

Revenue Loss for Employees of Firms without Insurance. The projected Revenue Loss from the changes to Payroll Tax and Income Tax Liabilities will depend on the rate at which tax payments to the Treasury are reduced. We assume that most taxpayers will adapt to the proposed change to FSAs by adjusting their withheld tax payments. The factor used to convert these reduced tax liabilities into lower revenues is 70 percent. This adjustment takes into account the fact that the federal fiscal year runs from October 1 to September 30, the following year.

Summing the current year's Payroll Tax Liability and Income Tax Liability computed above and multiplying this sum by 70 percent and the previous year's sum by 30 percent provides an estimate of the Revenue Losses for Uninsured Employees -- \$0.5 million in fiscal year 1991 and rising to \$11 million by 1996. Expressed in terms of the revenue cost per participating employee, the amounts range between \$13 per employee in 1991 and \$23 in 1996.

VII. Potential Adjustments for Other Factors

The Revenue Loss figures described above are conservative estimates of the likely reduction in federal tax revenue that could result if the HCAP proposal were adopted. There are a number of factors that could intervene to lessen this impact, though, which government revenue estimators often do not take into account in developing their own estimates. It is for this reason that we have chosen not to incorporate these elements directly into our own projections. These factors include reduced federal and state outlays for the medically indigent likely to result under the proposal, and the potential for increased economic benefits from funds accumulated in FSAs. Each of these effects is discussed in turn.

Reduced Medical Expenditures. Traditionally, estimates of the effects of changes in federal government policies have focused separately on the impact policy changes will have on revenues and on expenditures. The effects federal changes may have on state and local governments are rarely examined. This approach is often justifiable, because a federal policy may influence programs specific to a single sector of the economy or because the policy may affect federal expenditures or revenues exclusively (but not both).

In the instance of health care, however, public policies are so expansive that it would be inappropriate not to consider how federal and other governmental expenditures might be affected by the proposed change to FSAs. Under current law, individuals are implicitly guaranteed some minimum level of health care, regardless of their ability to pay. For some citizens, there are government programs specifically designed to cover their costs -- Medicare and Medicaid. Health care providers servicing others, who are unable to pay and whom government programs do not insure, shift these costs onto privately- and publicly-insured patients.

Any policy designed to expand insurance coverage among the uninsured, such as the HCAP proposal, will contain benefits in terms of reduced costs for government-sponsored health care. Families, for example, who may resort to Medicaid to cover catastrophic

illnesses or costly treatments may be somewhat less likely to do so if FSAs are made available. The HCAP proposal may also be beneficial from the perspective of reducing the strains the health care system faces from the continual shifting of uninsured patient costs.

Other Economic Benefits from Rollovers. Perhaps the factors most difficult to quantify in a revenue projection are those which alter economic behavior. It is recognized that different types of health care coverage may have implications for overall spending on medical care. Research on FSAs, however, has not been as extensive as that dealing with the effects of coinsurance and deductibles.

Studies have not been performed, for example, which examine how a rollover provision may affect the utilization of health care services. Under current law, participants in FSAs have an incentive to overutilize health care toward the end of a year when account balances are significantly greater than zero, since the excess amounts will be forfeited at year's end. A rollover provision could stem the incursion of unnecessary expenses by employees. And as an added benefit, unspent funds in FSAs could ultimately serve as a source of savings which could be put to productive use. Although the magnitude of this effect is probably too small to be detected in a decline in interest rates, its direction is unquestioned.

Appendix

Projection of Employees of Firms Offering FSAs
Qualifying under the HCAP Proposal

In this appendix, we project the potential number of employees with insurance who might qualify for the proposed rollover, if the proposal clause restricting total tax-favored health benefits offered employees to the previous year's level were not included. Without this requirement, some observers believe that the benefits of the rollover would be received primarily by those already insured and with FSAs and thus that overall tax-favored health care benefits per employee would rise. Following the approach used to project the revenue effect from currently uninsured employees who are likely to participate, the parameters governing the number of insured employees are first determined and then the revenue effect itself is calculated for currently insured employees.

Number of Qualifying Employees. As noted in the report, in 1987, 66.3 million employees were already insured. As a share of insured employees, those working in firms with 100 or more employees comprised 48 percent.¹

To determine the number of insured employees with FSAs, we rely on the 1989 Health Care Benefits Survey, which surveys firms with 1,000 or more employees. We assume that all employees offered FSAs are also provided with insurance benefits. According to the Survey, 41 percent of the responding firms offered their employees FSAs in 1989. This share is projected to grow by 8 percent in 1990.² Within these firms,

¹ See "The Economics of Health Insurance Offerings by Small Firms," Tables 2 and 3.

² See "Flexible Benefit Programs," 1989 Health Care Benefits Survey, Foster Higgins & Company, Inc.

however, only a small share of employees opted to participate in FSAs -- 16.9 percent in 1989. This share rose from the previous year's level by 5 percentage points.

We assume that the share of firms with fewer than 1,000 employees that offer FSAs is only half as large, because similar fringe benefits seem to be concentrated among larger firms. Because firms with fewer than 100 workers employ 52 percent of insured workers, we conservatively assume that the share of employers offering FSAs is about 30 percent in 1989, growing at the same rate indicated in the Survey for larger firms.³

Growth of Employees with FSAs. To determine the rate at which the number of employees with FSAs will increase, we rely on information on the rate of increase (a) in the number of insured employees; (b) in the share of firms offering FSAs; and (c) in the share of employees participating in FSAs.

Growth in insured employees -- Unpublished data from the National Center for Health Statistics' Health Interview Survey (HIS) indicate that between 1984 and 1989 the growth rate for the insured population was about 1 percent annually. (The HIS data show that 76.7 percent of 205.2 million -- the civilian population under age 65 -- was insured in 1984, compared to 75.9 percent of 214.3 million in 1989.) We assume that this 1 percent rate of increase also applies to insured employees and that it will remain unchanged over the projection period. Based on this assumption, insured employees are projected to increase from 68.0 million in 1991 to 70.3 million by 1996.

Growth in offering firms -- Similarly, the 8 percent increase in the share of firms offering FSAs between 1989 and 1990 is assumed to recur each year of the

³ I.e. 48 percent (Share of firms w/ 100+ employees) x 41 percent (Share offering FSAs) + 52 percent (Share of firms w/under 100 employees) x (1/2 x 41 percent) = 30.3 percent.

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projection period. This share, therefore, grows from 47.8 percent at the beginning of the projection period to 70.3 percent.

Growth in employee participation -- We assume that the share of employees opting to participate continues to grow at a rate of 5 percentage points a year. Thus in 1991, the participation share is 26.9 percent and, by 1996, it is 51.9 percent.⁴

FSA Contributions per Employee. We assume that contribution amounts per employee are the same as those projected for currently uninsured workers. Although employers presently offering FSAs provide more extensive fringe benefits than do firms not offering any insurance, based on the analysis of the attractiveness of employer-funded FSAs above, we expect to see only limited employer funding of FSAs. Employee resistance to reductions in other health benefits and infrequent savings opportunities for employers will limit the amounts employers will place in FSAs.⁵

Growth of FSA Contribution Amounts. Similarly, we assume that the growth of contribution amounts is the same as that projected for currently uninsured workers -- based on the economy-wide inflation rate. Although health care expenditure levels per employee may differ between employers currently providing insurance and those who do not, we assume that employers already offering benefits will have less incentive to switch to FSAs unless they are able to hold their "real" level of health expenditures relatively constant.

⁴ This is a fairly conservative estimate. Hewitt Associates report in "Flexible Compensation Programs and Practices, 1989" that employee participation within firms offering FSAs actually fell between 1988 and 1989 from 21 percent to 19 percent. It would appear that as employer coverage expands, the immediate effect is for the overall employee participation rate to decline, since newly eligible employees generally require some time before deciding to participate.

⁵ In addition, the recent IRS rule requiring that an employee's maximum contribution amount to an FSA be available during the entire year of coverage is also likely to reduce current FSA contribution amounts according to employee benefits consultants.

Induced Health Expenditures Caused by FSAs. Refundability is unlikely to cause any perceptible increase in medical spending by employees currently participating in FSAs, because, as we have noted above, many other forms of tax subsidies for health care are already available to these workers and their employers. Indeed, the inducement to spend is potentially greater under forfeitable FSAs, since funds not spent at year's end are permanently lost.

In its report on FSAs, HHS projected the changes in tax expenditures resulting from the introduction of both a forfeitable FSA and a refundable FSA. We derive the increase in expenditures due to the HCAP proposal as the incremental change in tax expenditures due to refundable FSAs for those employees who already participate in forfeitable FSAs. This figure equals 6.8 percent.⁶ Even this estimate may overstate the likely rise in expenditures, since employees will be unable to exercise direct control over the amount of funds placed in the FSAs that may be rolled over. The added inducement to participate for some employers and employees currently without FSAs, however, could offset this effect.

Amounts Rolled Over Annually in FSAs. We also project that the share of contributions rolled over will be 10 percent, even though the share forfeited by workers in large firms in 1989 was about half this level.⁷ We attribute this increase to less concern about the accuracy of the amounts initially placed in FSAs (noted before) and some inclination on the part of workers to shield a portion of their taxable income from tax by placing greater amounts than required in FSAs. The proposal's exclusive application to employer-funded rollovers and its restriction on these amounts to less than twice the catastrophic insurance

⁶ See "A Study of Cafeteria Plans and Flexible Spending Accounts," Table 3. Our estimate is based on a comparison of tax expenditures incurred under Plan B for the forfeitable FSA -- \$634 -- with those under the refundable FSA -- \$677, an increase of 6.8 percent.

⁷ See "Health Care Benefits Survey, 1989: Flexible Benefit Programs."

limit, though, are specifically designed to ensure that such permanent deferment opportunities are limited.

Market Penetration/Learning Curve. We project the same growth of market penetration assumed above, based on the relatively slow growth rates experienced thus far for currently permissible FSAs. 1989 estimates for firms with 1,000 or more employees indicate that several years after their initial availability, FSAs were offered by only 41 percent of large firms.

Employees' Marginal Tax Rates.

Payroll tax rate -- The combined employer-employee payroll tax rate (net of the employer business expense offset) is set at 12.7 percent, as before. The true rate could fall somewhat below this level, though, to the extent that employees currently participating in FSAs may be more likely to have wage incomes which exceed the payroll tax ceiling.

Income tax rate -- In the absence of specific information about the incomes of employees with FSAs, we assume that the average marginal income tax rate faced by these workers is the same as the overall rate assumed for all taxpayers -- 22 percent.

The total tax rate -- payroll tax and income tax -- faced by these employees is thus 34.7 percent.

Payroll Tax and Income Tax Liabilities for Employees of Firms with FSAs (Appendix Table 1). To project tax liabilities, we determine the number of Participating Employees with employer-funded FSAs. This term equals the product of:

- the Number of Employees currently Insured (68.03 million in 1991);

Appendix Table 1
Change in Payroll and Income Tax Liability for Employees Currently with FSAs Under Proposal

Calendar Year	1991	1992	1993	1994	1995	1996
Total Insured Employees (Millions)	68.03	68.48	68.94	69.39	69.86	70.32
Share of Employees Offered FSAs	47.8%	51.6%	55.8%	60.2%	65.1%	70.3%
Share of Employees Participating	26.9%	31.9%	36.9%	41.9%	46.9%	51.9%
Participating Employees (Millions)	8.8	11.3	14.2	17.5	21.3	25.6
#s After Adjustment for Smaller Firms (Millions)	6.6	8.5	10.6	13.1	16.0	19.2
Contribution Amount Per Employee	\$400	\$420	\$434	\$450	\$466	\$483
CPI-U	4.9%	3.5%	3.6%	3.6%	3.6%	3.6%
Increase Induced by FSAs	6.8%	6.8%	6.8%	6.8%	6.8%	6.8%
Share of FSA Funds Rolled Over	10%	10%	10%	10%	10%	10%
Penetration/Learning Curve	5%	10%	20%	30%	40%	50%
Payroll Tax Rate	12.7%	12.7%	12.7%	12.7%	12.7%	12.7%
Payroll Tax (\$ Millions)	1.8	5.0	13.0	25.4	43.0	67.3
Assuming no offset	0.1	0.3	1.0	2.0	3.0	4.0
Assuming partial offset	0.0	0.0	0.0	0.0	0.0	0.0
Assuming full offset	0.0	0.0	0.0	0.0	0.0	0.0
Income Tax Rate	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%
Income Tax (\$ Millions)	3.1	8.6	22.6	43.9	74.4	116.5
Assuming no offset	0.2	1.0	1.0	3.0	5.0	7.0
Assuming partial offset	0.0	0.0	0.0	0.0	0.0	0.0
Assuming full offset	0.0	0.0	0.0	0.0	0.0	0.0

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- the Share of Employers Offering FSAs to their employees (47.8 percent in 1991); and
- the Share of Employees Participating in FSAs (26.9 percent in 1991).

The value of this product, 8.8 million for 1991, is reduced to reflect the fact that the data describing the Share of Employers Offering FSAs and the Share of Employees Participating are for very large firms only. An adjustment for somewhat lower participation by smaller firms drops the Number of Participating Employees to 6.6 million.

We determine the change in tax liability per employee using three alternative sets of assumptions:

- First, we consider the assumption that the increase in employer spending on FSAs is not offset by a reduction in other employer-funded health expenditures. We refer to this assumption as the "No Offset" scenario.
- Alternatively, we consider that the increase in FSAs is offset by a reduction in employer spending elsewhere, but the availability of the rollover stimulates an overall rise in health care expenditures of 6.8 percent (as noted above). We refer to this as the "Partial Offset" case.
- Finally, we discard altogether the assumption that overall health care costs are likely to rise with a rollover. In this instance, there will not be any revenue consequences due to the availability of the employer-funded FSAs for currently insured employees. We refer to this assumption as the "Full Offset" situation.

In the description of our revenue projection, there is some justification for assuming a full offset. We have demonstrated that if employers behave as though they wish to contain overall spending for their workers' medical expenses, then they will be indifferent in many instances between spending to expand health insurance policies (by providing lower deductibles and less coinsurance) and to offer employer-funded FSAs. It is, therefore, reasonable to assume that increased employer expenditures on FSAs are likely

to be linked with reduced employer subsidies for health insurance premiums or with higher deductibles and higher coinsurance. Without taking into consideration the effects such changes may ultimately have on the demand for health care, such shifts, because they do not result in higher expenditures for employers or employees, must also leave total tax expenditures for health unchanged. (All are deductible business expenses and nontaxable to employees.) Thus, regarding employees already participating in FSAs, reductions to other tax expenditures should fully offset the revenue losses that may initially result under the proposal.

No Offset -- The balance of these projections follows the computation procedures outlined above for Uninsured Employees. Liabilities in the first year equal the product of:

- the Number of Participating Employees (6.6 million);
- the Payroll Tax Rate (12.7 percent) or Income Tax Rate (22 percent);
- the Contribution Amount per Employee (\$400);
- the Share of FSA Contributions Rolled Over (10 percent); and
- the Market Penetration Rate (5 percent); increased by
- the Additional Expenditures due to the Introduction of FSAs (6.8 percent).

The sum of the Payroll and Income Tax Liabilities equals \$5 million.

In subsequent years, the Number of Participating Employees increases as the Number of Employees Insured, the Share of Employers Offering FSAs, and the Share of Employees Participating all rise. As a consequence, the Number of Participating Employees grows from 6.6 million to 19.2 million by 1996. As was assumed above, the Contribution Amount per Employee will rise at the inflation rate (lagged one year), and the Market Penetration Rate will also climb from 5 percent in the first year to 10 percent in the second year, and then by an additional 10 percent each year thereafter. The Payroll Tax Rate, the Additional Expenditures

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due to the Introduction of FSAs, and the Share of FSA Contributions Rolled Over are assumed to remain unchanged over the projection period.

Partial Offset -- In this case, the computation procedures are the same as above with the following exception. Only the tax liability related to the additional health care expenditures that HHS believes might result from the availability of a rollover (6.8 percent) are considered. The sum of the Payroll and Income Tax Liabilities is under \$1 million in 1991 and equals about \$12 million in 1996.

Full Offset -- Assuming that employers will hold overall health expenditures for their employees constant, there will not be any additional tax liability resulting from the HCAP proposal.

Revenue Loss for Employees of Firms with Insurance. The projected Revenue Loss from the changes to Payroll Tax and Income Tax Liabilities under each of the scenarios is again lagged so that 70 percent is included in the current fiscal year. The resulting Revenue Losses in the case of "No Offset" are \$3 million in 1991 rising to \$164 million in 1996. Under the "Partial Offset" assumption the losses range between \$0.2 million in 1991 and \$10 million in 1996. Under the "Full Offset" scenario, there are, of course, no revenue consequences.

ALTERNATIVE BENEFIT DESIGNS: OPTIONS FOR STATE HEALTH POLICY

by John Begala, MA; Sandra Kuehn, MS; and Cathy Levine, MA

INTRODUCTION

Reducing the rate of growth in health care costs, while simultaneously increasing the number of Americans with health care coverage, is an enormously complex undertaking. In the late 1980s, spurred by the growing number of uninsured Americans, there emerged at the federal and state levels a wide range of proposals for reform of the health care system. Some of the proposals are broad and sweeping, such as the well-known Kennedy/Waxman and Pepper Commission plans. Others are incremental in nature and include Medicaid expansion, publicly-subsidized employer-sponsored benefits, and promotion of alternative benefit designs to extend "basic" health care services to the uninsured. While many argue that incremental approaches do not offer long-term solutions for improving access to care, given the current federal deficit and spending constraints, and the strong political forces which will hinder any efforts to radically modify the nation's health care system, reform initiatives in the near future are likely to be incremental and implemented at the state level.

An alternative benefit is one that is structured differently than conventional indemnity plans or health maintenance organizations (HMOs). Those that feature low out-of-pocket primary and preventive care coverage, coupled with limited coverage for other services, may offer the most appropriate and cost effective approach to addressing both access and cost containment concerns, especially for small businesses, which employ a disproportionally large number of the working uninsured.

OVERVIEW OF THE PROBLEM

Expenditures for health care have been spiraling upward each year with no apparent end in sight. The United States spent \$675 billion on health care in 1990, amounting to 12.4 percent of the Gross National Product (GNP) (Medical Benefits 1991). It is estimated that health expenditures will exceed \$1 trillion by 1995 (about 15 percent of GNP) (New York Times March 5, 1991). Such expenditures might not be viewed with alarm if all Americans had access to health care. But, there are 31 to 37 million Americans without health insurance, the majority of whom are low income workers and their dependents. An uninsured person, in a system relying heavily upon privately financed health coverage, has limited access to health care -- especially for primary and preventive care services.

The reasons for the crisis in health care are numerous and complex. Generally, there are several important factors contributing to both the rise in health care costs and the number of uninsured persons. First, the small business sector of the economy has been the source of most new jobs in the last decade, contributing eight times as many jobs as large businesses (U.S. Small Business Administration 1987). In 1987, only 46 percent of the 2.8 million firms with under ten employees offered health insurance, compared to virtually all firms with more than 500 workers (ICF Incorporated 1987). As a result of this growth in the small business sector, the number of working uninsured has grown steadily over the last decade, and is predicted to continue to grow through the 1990s.

Second, the business community has been seriously affected by escalating health premium costs, with average increases running considerably above the general rate

of inflation. For example, the average increase for group policies was 18 and 20 percent in 1988 and 1989, respectively (Hay/Huggins 1990). For small businesses, increases were an even higher, 22 percent in 1989 (Medical Benefits May 15, 1990). In response to these rising costs, many businesses have reacted by decreasing the levels of employee benefit coverage, raising employee premium contributions, eliminating or reducing employer contributions to dependent coverage or, in some cases, eliminating this employee benefit altogether. Each of these responses result in more uninsured workers or dependents.

Third, purchasers of health services, such as large employers with self-insured plans, the federal government, insurance companies, and managed care organizations, have begun to implement policies such as selective contracting, which reduce the ability of providers to cost-shift uncompensated care to their plans. As a result, access for the uninsured that has been financed through this "back door" is being further reduced.

CURRENT USE OF ALTERNATIVE BENEFIT DESIGNS

Across the nation, there are several alternative benefit designs being tested as part of publicly- and privately-sponsored demonstration projects, or offered on the market as private sector initiatives. Two such projects, Denver's Shared Cost Option for Private Employers (SCOPE), and the Alabama Coalition for the Medically Uninsured project, have been supported through the Robert Wood Johnson Foundation's Health Care for the Uninsured Program. Another project has been supported by the State of Ohio as one of several pilot programs, the Cincinnati-based Health Care Account Project (HCAP). In addition, a private sector initiative has been recently developed by Community Mutual Insurance Company,

a Blue Cross and Blue Shield organization in Cincinnati. Each program is unique, but all share in common the use of alternative benefit structures. Three of the four plans emphasize access to primary and preventive care.

Shared Cost Option for Private Employers (SCOPE)

The Denver SCOPE product is a low-cost, comprehensive, indemnity insurance plan for small businesses which was first offered in the Denver area, but is now available in most of Colorado. This Robert Wood Johnson Foundation funded project is sponsored by the Denver Department of Health and Hospitals and underwritten by New York-based United States Life Insurance Company.

SCOPE covers a wide array of primary and preventive care services with no deductibles or coinsurance, but requires small copayments for office visits and prescriptions. It also covers catastrophic medical expenses, but requires subscribers to bear more of the cost for these services through coinsurance of 50 percent up to \$5,000. Care is provided through a limited provider network, enabling the plan to achieve significant provider discounts. Premium rates are approximately 50 percent less than traditional plans available to small businesses in the Denver area (Alpha Center 1991).

The Central Alabama Coalition for the Medically Uninsured (BasicCare)

The Central Alabama Coalition for the Medically Uninsured is an initiative of the University of Alabama at Birmingham. BasicCare, the health plan developed by the coalition, is underwritten by Complete Health, Inc., the largest HMO in Alabama. It covers a limited schedule of benefits, focusing on primary and preventive care, with limited inpatient and outpatient hospital coverage.

Preventive and primary care (such as routine checkups, well child care, immunizations for children up to age five, hearing and vision screening) and office visits for illness or injury are all covered, some visits requiring a small copayment. There is a 20 percent coinsurance requirement for inpatient physician and surgeon services, anesthesia, and ambulance services after the subscriber pays a \$100 deductible (one per individual and three per family).

A unique aspect of the plan is that it offers employers a choice of two delivery systems, through either a network of private or public providers. The benefits and cost-sharing are the same, but the premiums for the public option are about 40 percent less. Subscribers to the public plan may receive primary care services only at specified health clinics and must use the public hospital for all inpatient and outpatient care or be referred to a participating hospital.

The limited schedule of benefits and discounts from participating providers enable BasicCare to offer lower than average premium rates. The monthly cost (February, 1991) for the private option was \$74 for individual coverage and \$186 for family coverage, while the rates were \$45 for an individual and \$110 for a family under the public option.

Health Care Account Project (PrimaryPlus)

PrimaryPlus is a fully-insured health benefit designed by the Health Care Account Project (HCAP), a pilot project funded by the State of Ohio to develop an innovative approach to expanding health coverage among the working uninsured. The plan is underwritten by Community Mutual Insurance Company (CMIC) in

Cincinnati and administered by both CMIC and a third party administrator.

PrimaryPlus offers a unique combination of coverage, featuring a strong emphasis on primary care through an insured medical spending account. Routine primary and preventive care are covered without a deductible or copayment, up to an annual "cap". There are no pre-existing condition limitations for these services. This insured medical spending account is coupled with a high deductible catastrophic benefit. There are two deductible levels: either \$5,000 per individual and \$10,000 per family; or \$10,000 per individual and \$20,000 per family. After the deductible has been met, the plan pays 100 percent of eligible expenses.

At the end of each calendar year, for each employer group, 85 percent of the group's unused primary care medical spending account is carried forward and distributed equally among subscribing employees, increasing the amount of funds available in each subscriber's primary care medical spending account for the subsequent year. PrimaryPlus also features a health credit assistance component to assist plan subscribers in obtaining a no-interest loan to cover health expenses that are unpaid due to the higher than usual deductible levels. Premium rates for PrimaryPlus are comparable to the Denver-based SCOPE plan. However, as a state-funded demonstration project, eligibility is restricted to small businesses that have not provided employer-sponsored insurance in at least 18 months prior to enrollment in the plan.

Community Mutual Insurance Company (Low Cost)

Over the past year, health insurance companies have begun marketing high co-

insurance "basic benefit" plans, designed to meet the small group market's need for lower premium costs while providing a high level of major medical coverage (Landes 1991). One such plan, developed in Southwestern Ohio by Community Mutual Insurance Company in Cincinnati, pays 70 percent of the cost of covered services, leaving subscribers responsible for the remaining 30 percent, subject to an annual out-of-pocket limit. Coverage is subject to an annual deductible of \$200 per individual and \$400 per family, and services must be accessed through a participating provider network.

Larger than customary coinsurance, at rates of 30 to 50 percent, is what characterizes this and similar products as alternative benefit designs. However, like many traditional indemnity plans, they usually leave uncovered a number of primary and preventive health care services through a high deductible.

STRENGTH OF ALTERNATIVE DESIGNS

There are several advantages to alternative benefits as an incremental approach to solving the health care access crisis. First, they can be implemented within the existing pluralistic system of health care finance and delivery. Second, they rely on private sector initiatives to health care reform that do not require controversial mandates directed at employers to provide health coverage or increases in public spending. And third, the flexibility of alternative benefit designs can allow coverage to be tailored to meet the needs of subscribers, including primary and preventive health services. SCOPE, BasicCare, and PrimaryPlus encourage the use of primary and routine care by limiting the out-of-pocket expenditures for these services. In HCAP's PrimaryPlus, primary and preventive services are covered in full up to an annual cap, (of either \$175 or

\$250 for an individual and either \$500 or \$650 for a family, depending on the option chosen) while Alabama's BasicCare and Denver's SCOPE provide coverage with only a small co-payment for some physician office visits. By emphasizing the use of primary and preventive services, these plans decrease the need for more intensive and costly services. And by requiring subscribers to pay a substantial portion of costs between the primary and catastrophic levels, they offer strong incentives for consumers and providers to contain unnecessary spending where utilization driven cost increases are the greatest.

As policy makers consider various incremental approaches to access issues, these plans bear careful consideration in that they raise the question of the extent to which private sector initiatives can play a role in a general reform strategy. Additionally, they call attention to the fact that primary care is relatively inexpensive when compared to total per capita health care expenditures in the United States. Research conducted by the Health Care Account Project estimated the annual per capita cost of primary care for persons under age 65 to be \$258 in 1991, or 15.8 percent of total personal health care expenditures (Begala, Kuehn, and Levine 1991). This figure represents the combined cost for services provided by office-based primary care physicians, including family practitioners, obstetricians/gynecologists, general practitioners, office-based internists, and pediatricians; preventive dental care; and prescription drugs. Because this definition of primary care is so broad, it offers an estimate of the cost for a variety of typical basic family medical expenses without suggesting or prescribing a fixed combination of benefits.

Alternative benefit designs also address the market demand for less expensive

products. The models discussed above allow insurers to reduce premiums or rate increases by limiting their exposure to risk, either by capping benefits or sharing risk with the subscriber.

POLICY IMPLICATIONS

A critical element in the design of any incremental health care reform package is the definition by policy makers of a "basic benefit plan." The experiences of the four initiatives described above can be of significant value to state policy makers, in that they demonstrate what can work, and what appears not to work, with regard to developing a basic benefit plan for uninsured workers. Specifically, these initiatives demonstrate (1) the desirability and relatively modest cost of primary care coverage, and (2) the acceptance in the market of higher than customary coinsurance plans and, conversely, the rejection of high deductible plans.

With the exception of Community Mutual's Low Cost plan, the appeal of each of the alternative benefits derives largely from an emphasis on primary care coverage. SCOPE insured over 6,000 lives in its first 18 months on the market, while Alabama's BasicCare insured 300 lives in 50 firms the first year. For PrimaryPlus, the main attraction to the plan has been the primary care coverage. However, as its low enrollment and extensive market research have indicated, its high catastrophic deductible has been a significant barrier to employers. Importantly, high out-of-pocket expenditures have not posed such a barrier for two of the other plans, which instead incorporated high coinsurance (SCOPE's 50/50 and Low Cost's 70/30) on expenses above the primary care level.

Taken together, the experiences of these initiatives clearly show the cost effectiveness and market appeal of first dollar primary care coverage combined with higher than customary coinsurance, and the resulting lower premiums. In these features, they vary significantly from the "basic benefit" designs included in generally known reform proposals. For example, the Kennedy/Waxman, Enthoven/Kronick, and Pepper Commission plans feature traditional deductible levels with no special provision for primary care, in effect increasing out-of-pocket expenses for primary health care needs while maintaining a traditional low coinsurance payment of 20 percent for catastrophic expenses. Such approaches represent a tacit denial of access to basic services for families with low to moderate incomes who comprise the vast majority of the working uninsured.

If state policy makers wish to promote market-based approaches using such alternative benefit designs, they must address regulatory and market problems which hinder efforts to meet the health insurance needs of small businesses. These include (1) the existence of various state mandates and federal IRS regulations which create barriers to developing alternative benefits designed to meet the needs of small businesses, and 2) the existence of insurance industry practices limiting coverage based upon pre-existing conditions and medical underwriting.

There are nearly 700 state-mandated health benefits requiring reimbursement of certain types of providers, coverage of certain types of health services and categories of beneficiaries (Meyer 1989). Such mandates, and other regulations imposed by states, have increased the price of health insurance to the point of pricing 9.3 million of the uninsured out of the market for insurance (Center for

Policy Analysis 1989). Not only have the mandates increased the price of insurance, but they prevent insurers from offering "no-frills" insurance at reasonable prices. Under federal law, Medicare enrollees, employees of self-insured companies, and federal employees are exempt from state mandates. Therefore, the full burden of the mandates fall upon those most in need of a low-cost product -- the owners and employees of small business, the self-employed and the unemployed.

Flexibility in developing alternative benefit designs to meet the needs of small businesses is also constrained by current federal regulations, particularly Internal Revenue regulation 1.125-2 governing cafeteria plans and flexible spending accounts. Funds accumulated in such accounts are subject to a "use it or lose it" provision which denies the pre-tax treatment of accumulated funds beyond the end of a plan year on an individual basis. Modifications to current regulations could help promote flexibility in the design of alternative benefits, encouraging employers and employees to create pre-tax savings plans in order to cover higher than customary coinsurance that is characteristic of successful alternative benefit plans.

As noted above, small businesses are the least likely employers to offer health benefits to their employees. And yet, the practices of insurance companies have created myriad problems in the small group market for employers and insurance companies. The practice of assessing risk for each small group based on its members' medical histories denies the very purpose of insurance, to spread risk. In the marketplace, this medical underwriting has created a "vicious circle" in which an insurer that desires to include a large number of small firms in a

community-rated pool is almost certain to have adverse selection, so long as other insurance companies medically underwrite their own small group products. Additionally, it creates pressure on employers to exclude employees and dependents with high medical costs, thereby disrupting the workplace while creating a barrier to health care services for those who most need it.

After medical underwriting, the use of pre-existing condition exclusions presents the most significant problem for small businesses wanting to insure their employees. Virtually all insurers include such exclusions in their small group policies. These generally provide that if an individual has been treated for a medical condition within a specified period of time before enrollment, payment will be disallowed for any care related to that condition for a period of time after enrollment, usually one year. This common insurance industry practice denies many benefits to people with chronic health problems, as well as millions of workers each year who change employers.

Consideration of these problems allows some generalizations regarding the wider use of alternative benefit designs in incremental reform strategies. First, federal Internal Revenue regulations and state insurance laws should allow greater flexibility so that alternative "basic benefit" products can be tailored to meet the benefit and cost needs of the small business market. At the federal level, there should be modification of internal revenue regulations which restrict pre-tax savings for health care services in flexible spending accounts. At the state level, there should be flexibility regarding compliance with mandates which are required of insurance products.

Second, the creation of risk pools in each state for people with chronic or other significant health care problems that make them "uninsurable" in the commercial small group market, would benefit hundreds of thousands of Americans. While not significantly reducing the total number of uninsured workers and their dependents, such actions would allow coverage and expand service access for some of the nation's most needy citizens, while relieving small group plans of a portion of their adverse selection problem. To date, 24 states have established such high risk pools (Trippler 1990).

Third, changes in insurance regulation of the small group market could alleviate problems confronting insurers and small employers. If all insurance companies offering small group plans in a state were required to practice community rating, the "competitive playing field" would be leveled and the benefits of spreading risk shared by all "players." This approach would be enhanced if combined with the creation of a reinsurance pool for all insurers operating in the small group market. Such pools can equalize the risk of large catastrophic claims, and the resulting losses that insurers can experience from significant adverse selection. And finally, pre-existing condition exclusions can be prohibited for those who have been "continuously insured," allowing for temporary interruptions beyond the control of the individual, such as layoffs or other periods of unemployment of short duration. Such reforms are being considered in a number of states and similar provisions have already been enacted in Connecticut.

CONCLUSION

There is considerable potential for using alternative benefit designs as an incremental reform strategy to meet the needs of a portion of the nation's

uninsured. Current insurance industry practices, as well as existing state and federal regulation of the structure, content, and sales of insurance products, impose significant barriers to the development and application of these products. Carefully crafted regulatory reform can remove these barriers, allowing a role for private initiative and the competitive market to expand health care access. While not allowing universal access and coverage, such an approach is far more realistic in the current economic, political and fiscal climate of the federal and state governments.

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John A. Begala, M.A., was Project Director for the Health Care Account Project in Cincinnati, Ohio. He has been a health and social services executive and consultant for nine years, after serving three terms in the Ohio House of Representatives.

Cathy A. Levine, M.A., was the Senior Health Planner for the Health Care Account Project. She has a Masters from the University of Chicago's School of Social Service Administration and has a broad background in health policy and planning.

Chairman STARK. Thank you. Mr. Weinstein, you think we ought to have some rules on group. I mean, no medical underwriting, community rating, open enrollment, that sort of thing.

Mr. WEINSTEIN. I agree.

Chairman STARK. OK. How would you deal with self-insured plans?

Mr. WEINSTEIN. I think that has been somewhat discussed, where you have people that get outside of the community rating. If they would be such, that would be problematic, and I think as mentioned before, some attention must be addressed to those people because they will siphon off the groups that have the best ability to get the insurance without really cross-subsidizing the remainder of the pool.

Chairman STARK. Would you force them to take everybody in the company? In other words, obviously one of the things you can do is prevent the self-insured plans from dumping their highest risks into the market.

Mr. WEINSTEIN. I think that is a question that I am not sure I know the total answer to, but I think it is one that must be addressed, or there will be problems still resulting in the system.

Chairman STARK. Mr. Naylor, tell me your restaurants again. I know you have some in the bay area.

Mr. NAYLOR. Personally, we operate or will operate by the end of this year about 14 restaurants in California. Our family business that my brothers and I had in the 1970's, we had about 37 restaurants. We had about 2,000 employees with 1,000 at that time under managed care, some of them under the old Taft-Hartley before we broke away and set up our own plans, spending even in those days about \$1 million a year. We modeled this trust up after that.

Chairman STARK. I assume that your—I don't know this, but only the full-time employees are under your plan?

Mr. NAYLOR. Yes, that is true.

Chairman STARK. Roughly, in each restaurant, what is the percentage of full-time employees, and how do you define them?

Mr. NAYLOR. The restaurant business is kind of a variety of different businesses within the business. The fast food is certainly different than fine dining, and it will run in the neighborhood of about 50 percent in the family fine dining segment and as little as 25 percent or so in the fast food end of it, where they have a great deal more kids and part-time and summer-time.

It is not that they are not insured with their families or school or whatever, but they are just not full-time employees.

Chairman STARK. But probably not more than 50 percent full-time, even in the plushiest table cloths?

Mr. NAYLOR. That is right.

Chairman STARK. And I guess therein lies our problem, and I am not sure how you deal with it, but it indicates the uninsured we have. Can you—

Mr. NAYLOR. Let me give you one example.

Chairman STARK. No, I mean it is just a different issue. If somebody works 10 hours or just works weekends or just does valet parking and works 1 night a week, what do you do?

But can you tell me what you pay a month in your coffee shops or in your restaurants in California? We are going to hear from

Blue Cross California later, and I am just trying to get a price, the rough cost. How much a month?

Mr. NAYLOR. The costs go all the way down for the under-30 group—our industry is average age 28 and 58 percent female—the under-30 group in the \$70 bracket—

Chairman STARK. A month.

Mr. NAYLOR. A month—all the way up to, gosh, I guess close to \$200 for the over-50, although we now have in California—

Chairman STARK. Your trust—

Mr. NAYLOR [continuing]. I was taking the 65-year-old, the most expensive group out of our plan, and insuring that under Medicare.

Chairman STARK. Yes, but your restaurant trust then has an age-related premium?

Mr. NAYLOR. Yes, it does.

Chairman STARK. Can you summarize—are your benefits pretty standard? Do you have just one benefit plan, or do you have a variety?

Mr. NAYLOR. We have quite a variety. We have high, medium, and low option.

Chairman STARK. What is low option? Can you outline the package?

Mr. NAYLOR. It would be \$15 when you go to the doctor instead of \$10 or \$5, that type of thing. The HMO is 90 percent of our business, the indemnity is 10 percent.

Chairman STARK. Who is your HMO? Do you use Kaiser?

Mr. NAYLOR. Cigna Ross Loos, in southern California. We have used Kaiser in the past, but our rate with Cigna Ross Loos and this group has been better than that of Kaiser's community rate for the most part because of that group—the age of that group and the makeup of it.

We have a lot of maternity. We have the cost of the plan—we picked up the McDonald's franchisees this year in southern California. They left their California plan. The largest insurer in that group—or one of the largest ones—had 10 stores. He had 54 employees insured when he came on board, so that is a little over five per store.

Because of the cost of this plan, he broadened his share of the contribution. They now have over 100 people insured in those 10 stores by him making substantially more contribution.

The toughest job we have is convincing somebody 20, 21, 22 years of age to even spend \$10 a month for health care. They have never been sick a day in their life, and at that age they are immortal and—

Chairman STARK. Well, that is what I wanted to ask each of you. I mean, you are all here—or two of you, Mr. Weinstein, not necessarily—but certainly the National Federation of Independent Business and you represent small to medium-sized business. Is that a fair statement?

Ms. MILLER. You could even drop off the medium sized.

Chairman STARK. Well, not in the restaurant business. They move up pretty quick.

Mr. NAYLOR. Seventy percent of our business does less than \$500,000 a year in sales, but we do have some large companies that

also are now participating in the trust. It originally was thought to be a small group trust, but it is really more industry specific.

Chairman STARK. What would your reaction be if I said to you one of the biggest problems we have is getting rid of the vestigial arrangement that we have to get health insurance, that is, through our place of employment?

It was a wonderful arrangement in 1940 when it came into existence. You had one parent who worked, generally at one job through to retirement. Kids, unlike kids today, didn't have six or seven parents before they reached majority, and families didn't have two employers. But now, why should your wife's employer pay for your kids just because her plan has a more generous benefit? There is a whole host of inequities, and a whole lot of people aren't even in the system. They only work 16 hours a week at Cliff's coffee shop, and you won't take them unless they work 20.

Now, I am not suggesting that you shouldn't end up paying as an employer, but does it offend you to imagine that you walked into a new town, and there was a city law that says everybody in this town has health insurance. And there is a minimum plan, and as an employer you pay \$1 an hour for the community plan or you provide a plan that is equivalent, let us say, to the low-option Blue Cross, and then you don't have to pay.

Would that bother you? Seeing that the cost is about the same you would pay anyway, would that bother you?

Mr. NAYLOR. Well, I think from my perspective the health insurance program would bother me a great deal because of the amount of hours worked in our industry, it would be a tremendous burden on the restaurant industry to subsidize the rest of the unemployed. There are lots of other industries that have very few hours worked—

Chairman STARK. But what if I told you, you are doing that already, your costs are higher—

Mr. NAYLOR. That is true.

Chairman STARK. Because of the half of the employees that don't have health insurance that end up in an emergency room, and therefore the hospital jacks up its costs to your insurance company. I am not sure I could convince you.

I guess what I am trying to get at is this. Is there anything magic, anything that you are wedded to that says health insurance has to be employment based? Let us say it didn't cost you any more in a public plan, but all you had to do was pay, not worry about the administration. Would that trouble you?

Mr. NAYLOR. I really believe that if the cost were the factor, if we could provide this insurance at a lower cost, there is no question in my mind we would have this participation that we are looking for.

In fact, the mandates in California cost us 15.3 percent from that standpoint, and we are looking forward to trying to put something together to get the enrollment up in restaurants in health care so that there is 24-hour coverage for your workers' comp and health care combined. We have this much higher enrollment base. And we are really looking at the best catastrophic plan that we can at the least cost.

To the extent that they have talked about moving the trust—it is domiciled in California—outside of the State into another State where we would be under ERISA and not have to have those mandates as a part of it, I really believe that the participation in those restaurants that we are looking for would rise dramatically with reduced costs.

Ms. MILLER. Our NFIB members, we polled them on the pay or play idea, and 94 percent opposed the idea. Notice in the way I structured my remarks—

Chairman STARK. But you are not answering what I am asking you.

Ms. MILLER. I am getting to that.

Chairman STARK. OK.

Ms. MILLER. We don't think that the employment-based system is an anachronism. We also, though, don't believe that it is the only way to take care of the problem, which is why I focused so heavily on the individual purchaser and I also focused on nontraditional aspects.

Insurance is not the only way you can pay for health care. We don't have to use insurance as a prepaid medical plan. The focus needs—

Chairman STARK. Maybe I am missing something—what else would you do?

Ms. MILLER. Well, I mentioned community health based programs as one example of how you can use something not—

Chairman STARK. Who pays for it?

Ms. MILLER. Excuse me?

Chairman STARK. Who would pay for that? I mean, I am missing something. You are saying, either you have a pool—I don't care whether you call it insurance or a community—or each person is on their own and they pay for their own costs out-of-pocket. Is there an alternative? Maybe I am missing something.

Ms. MILLER. I guess I am not following where you are saying—

Chairman STARK. You are saying—if you don't have insurance, what do you have?

Ms. MILLER. Well, that is where you need to strengthen your programs which complement the employment-based system, and yes, those do need to be paid for. But to rely solely upon insurance as a means to pay for health care, you are not going to get the best bang for your bucks and hit the right target audience.

You are not going to hit inner-city youth by trying to get employment-based health insurance.

Chairman STARK. Therefore, you have to have some other kind of insurance, like social insurance, we will call it, for lack of a better word.

Ms. MILLER. I don't think I would use the term insurance. To our members, insurance is a risk transfer mechanism. It is not a payment mechanism.

Chairman STARK. They are wrong. You ought to educate your members. It is a risk avoidance mechanism on the part of the insurance companies, admittedly, but unlike life insurance or fire insurance, it is a payment pool, pure and simple. You would do them a service if you educated them to that.

Ms. MILLER. The way our members—

Chairman STARK. There isn't a lot of risk pooling or risk transfer that goes on. As I say, there is avoidance.

Most employers, for example, aren't troubled, I don't suppose. They don't like the premiums at all, but I have never heard your group or any other group suggest that we ought to go to private unemployment insurance, have you? Would you like that, to buy your unemployment insurance from Travelers?

Ms. MILLER. I can't speak to that.

Chairman STARK. Mr. Naylor? And quite frankly, most of you don't really shop your workman's comp that much. In California, you either buy the State system—you have trouble beating it privately. You could go to a private insurer if you really want, but don't you buy the State program?

Mr. NAYLOR. Yes. We have about 25 to 30 million dollars' worth of workman's compensation through our restaurant association.

Chairman STARK. Do you ever survey your membership about workman's comp?

Ms. MILLER. At the State level, we do.

Chairman STARK. What do they say about it?

Ms. MILLER. The No. 1 problem that they have is rising premiums. They are rising faster than the private insurance.

Mr. NAYLOR. If I could address that one for a second, though, because that is an interesting adjunct to what we are doing here. We really believe the next biggest opportunity to reduce costs and improve health care for our employees is by combining these managed care, the HMO networks, and providing workmans' comp benefits as well.

Under the same principles of managed care that you have, if somebody got injured on the job, why not go to the same doctor at the same facility or an adjacent facility—

Chairman STARK. I will give you an example about a problem with managed care. There is a plan called MD-IPA, and if anybody in the audience belongs to it, you should get out. [Laughter.]

One of my employees for whom English is a second language joined MD-IPA, one of the Federal managed care plans, and they got a book. You could only go to the doctors in the book.

And it says in the front of this book that this is a quality plan, and they emphasize the quality of their providers. They are lying. They don't care.

I called, unannounced and unidentified, and asked about a particular physician in a particular community, such questions as was this person an M.D. If so—the doctor held himself out to be an internist—I wondered maybe whether they looked at a board exam or even if he had ever even passed one or had the certificate.

I was told in no uncertain terms that it was none of my damn business, and if I wanted to find that information out, I should call the county medical society, and they hung up on me.

Now, I hope that those people are off the Federal employees' lists next year. It is MD-IPA, if anybody cares. [Laughter.]

They are in trouble. But that is the way you manage care. You buy cheap doctors—

Mr. NAYLOR. I don't believe you would say that—

Chairman STARK [continuing]. And you ratchet the hospitals down, and you don't really give much of a hoot whether the employees get—

Mr. NAYLOR. I don't think you would say that about Kaiser and Cigna Ross—

Chairman STARK. No. You can't say it about Kaiser, which is probably one of the finest in the country, but—

Mr. NAYLOR. That is who I am talking about.

Chairman STARK [continuing]. Boy I could give you examples in State after State that managed care means a big purchaser ratcheting down on some provider. Then, to make ends meet, the provider has to kick the costs up to somebody else, maybe one of your members whose costs therefore go up because the ABC manufacturing company has 50 percent of the jobs in the city so the local hospital is going to give them a discount. But your member who has three or five employees pays the top rate and gets hurt.

It may be that we can cut costs through HMO's, but I don't think politically we will ever be able to direct the citizens in this country as to what type of a provider to go to. I would imagine this committee would say we won't even try.

But maybe we can go for all of them to basically a single-payer or an all-payer system. So no matter whether it is your trust or the insurance company you would like to buy from, the hospital in your town charges one rate.

And the tradeoff to the hospital is that they get paid by everybody who gets delivered to them, whether they are an indigent emergency patient or not. And they will all be better off, I think.

That is the only way I know that any witness before this committee has been able to testify that the entire system could save money. We will hear a litany of people who will say they will save money for their clients, but the fact is that somebody else's clients are going to pick up that bill.

It is just like squeezing a balloon. You squeeze here, and it pops up over there.

Mr. NAYLOR. I think that is true of what we have actually attempted and accomplished over the last 15 years. We have saved money for the restaurant industry, because we have proved that it is a good place to insure, and so we are paying less for insurance today than we would have been absent this trust or this kind of mechanism.

I think it is also true, though—and I am not taking exception to you, I am in fact supporting what you are saying here—

Chairman STARK. I need all the help I can get—

Mr. NAYLOR [continuing]. The same thing can be accomplished in workmans' compensation using those HMO's and those facilities. You get to see your own doctor, and he has your records.

Chairman STARK. I just used that as an illustration that really businesses don't object more to unemployment insurance. They don't like it, but they are really not out saying, gosh, we ought to have private unemployment insurance.

Nobody is suggesting that businesses take over the cost of insuring their retirees. I mean, there is \$400 billion of retire benefit liability waiting to hit them on their balance sheet, and you are not

hearing any businesses coming here saying, let us out of Medicare, believe me.

As a matter of fact, in those areas like the State of California where the teachers weren't under Medicare, they are coming in every year saying, can't we get in for less? So nobody objects to Medicare as a universal government insurance plan.

The seniors love Medicare. The only thing I think that could generate more postcards of dubious value than the Federation for Independent Businesses is Jimmy Roosevelt's group. If someone suggested that we do away with Medicare, they would out-postcard the National Institute for Independent Business or whoever it is who writes a lot of postcards.

Do you belong? Do you belong and send in those postcards?

Mr. NAYLOR. No, I am not quite that senior yet, but I am getting ready to—[Laughter.]

Chairman STARK. No, I didn't mean that. No, no. [Laughter.]

I meant the National Federation of Independent Businesses—Ms. Miller's group.

Ms. MILLER. We don't postcard.

Chairman STARK. You don't postcard?

Ms. MILLER. No, we don't postcard. If you get a letter from an NFIB member, that came from the NFIB member.

Chairman STARK. Well, what about the postcard in the magazine, the survey? Don't you do a survey?

Ms. MILLER. Oh, the mandate poll.

Chairman STARK. Yes. I mean a whole bunch of polls.

Ms. MILLER. You get a poll every other month.

Chairman STARK. Yes.

Ms. MILLER. That is not a postcard. They honestly decide whether to support your mediplan or Mrs. Johnson's bill or Mr. Russo's bill.

Chairman STARK. I understand that. A form.

Mr. NAYLOR. Could I maybe add one other thing that we have been able to accomplish that I heard some testimony to the contrary earlier. That is the health question and the exclusions for health problems.

Under the indemnity plan—and it is only about 10 percent of what we do—we do have health questions and so forth. But under our managed care, HMO-type plans, there are none, and rarely is anybody ever excluded. I will tell you some exceptions to that.

Because of the age and because of the amount of maternity, we ask women in the third trimester—try to actually get in front of them to find out if they are willing to make that change. If they are not, then we go back to the employer and ask him to wait 2 or 3 months before he changes health care, because that is a time when they are getting ready to deliver. They have their doctor and their hospital all lined up.

So with the exception of that trimester of pregnancy, there are very few other types of medical questions we get in front of those people on, and that is something that I think is available to everybody if they can negotiate that into their system.

Chairman STARK. I thank the panel. Your testimony has been helpful, and we will look forward to keeping those postcards

coming—and to working with you as we wind through this problem in the months ahead.

Our next witnesses are a panel consisting of the insurers, the Health Insurance Plan of Greater New York, represented by Karen Wintringham, the vice president of corporate development; Capital Blue Cross, represented by Lee Van Valkenburgh, the senior director of public affairs; Celtic Life Insurance Co., represented by Howard Bolnick, its president; and from the great State of California, Len Schaeffer, the chairman and CEO of Blue Cross of California.

Ms. Wintringham, do you want to lead off?

STATEMENT OF KAREN WINTRINGHAM, VICE PRESIDENT FOR CORPORATE DEVELOPMENT, HEALTH INSURANCE PLAN OF GREATER NEW YORK

Ms. WINTRINGHAM. Good afternoon. I am Karen Wintringham, vice president for corporate development for the Health Insurance Plan of Greater New York, which I may refer to as HIP. We certainly appreciate the opportunity to testify today.

We believe strongly that employees of small businesses and their families should have access to comprehensive, community rated benefits without any exclusions based on health status. This belief emanates primarily from our own experience serving some 23,000 members who represent about 2,700 small employer groups.

HIP is a not-for-profit, prepaid group practice plan HMO founded in 1944. Today HIP is the largest HMO system in the Eastern United States. We serve a diverse membership of some 1.1 million members in the five boroughs of New York City, the New York metropolitan counties of Nassau, Suffolk, and Westchester, and through our affiliated plans in New Jersey and southeast Florida.

Our longest and most extensive experience enrolling small business has been in New York, and so my comments primarily focus on that service area.

We offer the coverage on a community-rated basis, with no deductibles, no copayments, and no exclusions based on health status—such as health screening, preexisting conditions, or any sort of waiting periods.

The benefits we offer to these companies include HIP's full range of comprehensive services. In contrast to some of the testimony presented before this committee in the past year, the utilization experience of these small groups has not exceeded that of HIP's community-wide rates. In fact, it has been significantly lower.

In our written testimony, we present more detailed explanations both of our traditional program for small businesses and of a demonstration project we have run for 2 years where we offer heavily subsidized coverage to small businesses with previously uninsured employees and their families.

This latter experimental program has really provided us the opportunity to collect additional data and perform analyses that we do not usually have the opportunity to do. We would like to share with you some of our preliminary observations.

First of all, enrollment has been exceptionally slow and it has been concentrated in only a few of the categories of small business-

es. Approximately half of all participants have come from service companies.

Chairman STARK. This is——

Ms. WINTRINGHAM. This is the demonstration program for——

Chairman STARK. And it is about \$110 a month for an individual, is that what I am reading?

Ms. WINTRINGHAM. Yes, half of——

Chairman STARK. 50/50——

Ms. WINTRINGHAM. Half of which is paid by the employer, correct.

Marketing administrative functions for this project have been disproportionately expensive, especially with the smallest small businesses, namely those with fewer than three employees enrolling. Eighty-four percent of participants have come from companies with fewer than six employees, and more than half have come from companies with one employee.

We also have experienced extremely high disenrollment rates, which we believe primarily reflect the precarious financial condition of many of the small businesses in our New York service area.

In an effort to encourage continued participation, we have had to tailor our traditional payment policies to adapt to the payment practices of these small businesses.

Chairman STARK. Sort of like mine.

Ms. WINTRINGHAM. Right. And of the employers who have explained to us why they have chosen not to participate in the demonstration, a significant number of them state that they believe that their employees have coverage through a spouse, and so the employer is unwilling to pay for additional coverage.

Mr. Chairman, our experience serving small businesses throughout the HIP system has led to our strong belief that such coverage could be provided by all major carriers without significant risk, and could be reasonably priced.

In our written testimony, we present principles that we believe should be included in any proposal to address the health insurance needs of small businesses. I would just summarize those principles as follows.

All carriers participating in the small employer market should be required to accept and renew any legitimate small employer group. Small employers should be required to offer a choice of carriers, including HMO's where they are available.

Carriers should be prohibited from excluding individuals or groups based on health status. Carriers should be required to community rate these small businesses.

Cost-efficient plans should be allowed to offer additional benefits beyond a reasonably comprehensive minimum required benefit package, which includes preventive services.

Employees and their families should not have to pay significant out-of-pocket costs through high deductibles or high copayments. The capacity problems of group practice HMO's participating in a guaranteed issue environment should be recognized.

Participation in reinsurance pools, if they are established, should be voluntary for carriers which assume full risk for their members. And finally, relief from the extensive array of current State-mandated benefits may be appropriate on a State-by-State basis.

Mr. Chairman, we offer our experience and our view that reforms can be enacted to address the problems that your committee has identified. We hope to continue to work with you as you strive to find equitable and affordable solutions to making health care available to all.

I certainly would be happy to entertain any questions you may have. Thank you.

[The prepared statement follows:]

HEALTH INSURANCE PLAN OF GREATER NEW YORK
STATEMENT ON
REFORM OF PRIVATE HEALTH INSURANCE

PRESENTED BY
 KAREN WINTRINGHAM
 VICE PRESIDENT FOR CORPORATE DEVELOPMENT
 BEFORE THE
 SUBCOMMITTEE ON HEALTH
 COMMITTEE ON WAYS AND MEANS
 U.S. HOUSE OF REPRESENTATIVES
 MAY 23, 1991

Mr. Chairman, members of the Subcommittee, I am Karen Wintringham, Vice President for Corporate Development of the Health Insurance Plan of Greater New York (HIP). I am accompanied by Mr. George Strumpf, HIP's Vice President for Government Relations. We appreciate the opportunity to testify today and present our recommendations for reform of private health insurance focusing on small businesses.

We believe that employees of small businesses and their families should have access to comprehensive, community-rated benefits without exclusions based on health status. Our views emanate from our own experience enrolling and meeting the health care needs of small employer groups and previously uninsured small businesses, experience we would like to share with you for your consideration.

BACKGROUND

HIP is a not-for-profit prepaid group practice plan HMO founded in 1944. Today HIP is the largest HMO system in the eastern United States, serving approximately 1.1 million members in the five boroughs of New York City, the New York metropolitan counties of Nassau, Suffolk, and Westchester, and through its affiliated plans in New Jersey and southeast Florida.

Membership in HIP is diverse. In New York, for example, over 7,000 employer groups offer HIP benefits to their employees. This includes Fortune 500 companies, the Federal, State and City governments, and middle and small size employers. More than 100,000 Medicare and Medicaid members participate. HIP's enrollment of employees in small businesses is largest in New York. Hence, our testimony will focus primarily on the experiences of our New York plan and its affiliated Medical Groups' efforts to meet the health needs of employees of small businesses, including uninsured small businesses.

HIP's SMALL BUSINESS PROGRAM

In New York, HIP has offered comprehensive health coverage for employees of small businesses and their families for many years. In 1988, we significantly enhanced our marketing effort to businesses with 3-24 employees. Coverage is offered on a community-rated basis, with no deductibles, no copayments, and no exclusion of any kind based on health status (i.e., no health screening, pre-existing conditions, or waiting periods.) The health benefits include HIP's full range of comprehensive services. The absence of underwriting restrictions based on health status and the use of community rates are consistent with HIP's enrollment policies for large employers and accounts.

HIP's enrollment of small businesses has grown rapidly since the introduction of our enhanced marketing effort for these accounts. Current enrollment of 22,000 members represents approximately 2,500 small businesses in the five boroughs of New York City. These accounts are all offered a "dual choice" option, like that available to larger businesses, of an indemnity plan and of HMO coverage through HIP. HIP does limit coverage to accounts in which at least 3 employees enroll in either of the plans offered. This approach meets several objectives, including expanding consumer choice and offering an HMO's less costly, more comprehensive alternative to traditional indemnity coverage. The 1991 premiums for the two options are presented below:

SMALL BUSINESS PREMIUMS

<u>MONTHLY RATE</u>	<u>HIP</u>	<u>INDEMNITY PLAN</u>
Individual	\$111.94	\$183.80*
Family	\$291.07	\$429.25*
Medicare	\$39.00	\$127.80*
	No Deductible	\$200/500 Deductible

*Rates as of March 1991 for the most popular indemnity benefit package offered.

In contrast to some testimony presented to this Committee during the past year, the utilization experience of these small groups has not exceeded that of HIP's community-wide use rates. This experience seems consistent with that of other prepaid group practice HMOs who have testified before this Committee.¹

UNINSURED SMALL BUSINESS - BACKGROUND

Since 1983 the state of New York has made efforts to address the problem of the uninsured. The primary method used was reimbursement of hospitals through a Bad Debt and Charity Pool created from assessments of hospitals' revenue. Although the method provided some reimbursement for uninsured patients, the inherent incentives did nothing to redirect patients to the most cost effective setting or to preventive services. In recognition of these limitations, legislation was passed in 1988 to explore the use of alternative approaches. The Expanded Health Care Coverage Act of 1988 authorizes the use of a defined portion of Bad Debt and Charity Care funds to initiate insurance-based approaches for meeting the health needs of uninsured citizens. The demonstrations authorized by the Act thus represent a cooperative effort among the private, public, and voluntary sector.

HIP, in conjunction with the Brooklyn Economic Development Corporation (BEDC), has operated a demonstration program under this authority since May 1, 1989 for uninsured small businesses. The HIP/BEDC program provides an incentive program to offer comprehensive HMO benefits throughout the borough of Brooklyn. BEDC is the largest, oldest development corporation in the community, and has lent vital support through its established relationships with small businesses in Brooklyn and through its efforts to market the demonstration.

In order to qualify for participation in the voluntary program, the small business must meet the following criteria:

- o Employ 20 or fewer full-time employees
- o Has not offered health insurance to employees on or after January 1, 1988
- o The business must be located in Brooklyn.

¹ Testimony of Kaiser Permanente on health insurance in the small group market, April 3, 1991: Subcommittee on Health, Committee on Ways and Means.

As in HIP's small business program, this demonstration plan offers coverage with no deductibles, no copayments, and no exclusions of any kind (screening, pre-existing conditions, or waiting periods) based on health status. The comprehensive benefits offered include all inpatient and outpatient services usually offered by HMOs. The benefit package excludes coverage of outpatient prescription drugs.

Under the demonstration, HIP assumes full financial risk for all covered services and guarantees renewability for every account. Unfortunately, national and regional data do not exist that define the health needs of uninsured populations and whether they differ from those of persons covered by health insurance. Therefore, HIP did incorporate two policies to address potential, but unknown, risk. First, every full-time employee must participate in the program. Second, members who leave employment with the small business are guaranteed conversion rights with HIP, but only after participating in the program for six months.

As mentioned earlier, the premiums developed for the demonstration project are community rated. HIP elected to subsidize all administrative costs and costs related to the demonstration, removing these components from the community rate. The resulting rate is then shared equally by the employer (50%) and the Hospital Bad Debt and Charity Pool (50%). Employees do not make any financial contribution for their coverage. The 1991 monthly premiums for the project are presented below:

UNINSURED DEMONSTRATION PROJECT PREMIUMS

<u>Member Category</u>	<u>Employer's Share</u>	<u>State's Share</u>
Individual	\$54.53	\$54.53
Family	\$141.79	\$141.79

Owners of the small business wishing to participate in the project may do so but do not receive the premium subsidy.

UNINSURED SMALL BUSINESS - PRELIMINARY RESULTS

Definitive conclusions about the demonstration project would be somewhat premature. Hence, we present our preliminary results and will provide the Committee with our final analyses when they are available at the conclusion of the project. Data presented describe our experience from May 1, 1989 through December 31, 1990.

To date, some 1,200 members, the employees and families of 173 small businesses have participated in the program. Since the beginning of the program, 426 members have disenrolled and 20 companies have elected not to continue participating. Some of the members disenrolling from the demonstration remained enrolled in HIP either as individual members or as new employees of a different company. The significant disenrollment rate experienced in the demonstration is characteristic of our system-wide small business program. According to anecdotal reports, the disenrollment reflects the precarious financial condition of small businesses in our service area.

As outlined in the table below, the majority of participating companies are service companies. If one includes professional companies (i.e., doctors and lawyers offices) in this category, it represents 49% of companies participating in our program.

TYPE OF COMPANIES PARTICIPATING IN DEMONSTRATION

<u>Company Type</u>	<u>Number of Companies</u>	<u>Percent of Companies</u>
Service	55	36%
Retail Trade	37	24%
Professional	19	12%
Manufacturing	11	7%

Financial/Insurance	8	5%
Construction	7	5%
Transportation	5	3%
Wholesale Trade	2	1%
Agriculture	0	0%
Unclassified	9	6%
Total	153	99%

A second clear distinction identified is the small size of the participating companies. Since all full-time employees must enroll in the demonstration, we have defined company size as the number of HIP contract holders. This errs in the direction of undercounting, since it excludes the owners of the business and may exclude part-time employees. However, given our definition, 84% of participating companies have fewer than 6 employees, with the majority of those having only 1-3 employees.

SIZE OF COMPANIES PARTICIPATING IN DEMONSTRATION

<u>Company Size</u>	<u>Number of Companies</u>	<u>Percent of Companies</u>
1-5 Employees	129	84%
6-10 Employees	19	12%
11-15 Employees	5	3%
16-20 Employees	0	0%

The data collected to date on use of medical and hospital services confirm our experience with small businesses generally. The use rates of health services does not exceed HIP's average use rates. The use rates for the demonstration have been significantly below our average, despite efforts to encourage members to use the services. Of the hospitalizations covered thus far, the majority were for pregnancy-related services. However, it is premature to determine whether the low use rates and concentration on pregnancy-related services generally characterize the uninsured small business market and will remain stable.

Several other preliminary observations may be noted:

1. Under our voluntary system, enrollment has been exceptionally slow and concentrated in only a few of the categories of small businesses. We do not yet know whether this has resulted from the subsidy level, the fact that the program is being offered only as a demonstration, or other factors such as the restriction on the prior offering of insurance. Clearly the decision of a small business owner to begin offering health benefits for employees, even at the significant subsidy provided under this demonstration program, represents a significant financial commitment. Research will be conducted to try to document the nature and magnitude of the causes for lower than expected levels of participation, and we will share that information with the Committee when it becomes available.

It appears that the legislated requirement that the business may not have offered insurance since 1/1/88 will be amended by the State to a much more recent date. Such a favorable change will have a measurable effect on the number of small businesses which would qualify for the demonstration program, but it is not known whether the change will increase the number of companies which elect to participate.

2. Marketing and administrative functions for this voluntary project have been disproportionately expensive, especially with such small businesses (fewer than 3 employees) enrolling. These businesses rarely have an employee designated either to understand or make decisions about health coverage; speaking with a

company representative to explain the program takes that person away from his or her regular business responsibilities. In addition, a significant number of the owners speak languages other than English or Spanish. Korean, Arabic, Chinese, Hebrew, and West Indian languages are quite common, but the volume of enrollment has not justified the printing of literature in so many different languages. Once enrolled, ongoing communication with the health plan may also prove difficult.

3. If we used the traditional policy requiring monthly premium payments from accounts within 30 days, terminations of these small businesses would be significantly higher than presented earlier. In order to encourage continued participation in the demonstration, HIP has extended the usual payment deadlines and worked closely with accounts to develop workable payment arrangements. For example, we have found that many small businesses routinely make quarterly payments for goods and services, with insufficient clerical staff to issue monthly payments.
4. Of employers who explain why they elect not to participate in the project, a significant number believe their employees have coverage through a spouse, and so are unwilling to pay for additional coverage.

RECOMMENDATIONS

Our experience serving small businesses throughout the HIP system has led to our opinion that such coverage could be provided by all major carriers without significant risk and could be reasonably priced. We believe the following principles should be included in any proposal to address the health insurance needs of small businesses:

1. Guaranteed issue and renewability - All carriers participating in the small employer market should be required to accept and renew any legitimate small employer group. Small employers should be required to offer a choice of carriers, including HMO's, where available.
2. Pre-existing conditions, waiting periods, or other exclusions based on health status - Carriers should be prohibited from excluding individuals or groups based on health status.
3. Rating method - Carriers should be required to provide community rates to companies meeting the definition of small business.
4. Benefits - Cost efficient plans should be allowed to offer additional benefits beyond a reasonably comprehensive minimum benefit package which includes preventive services. Employees and their families should not have to pay significant out-of-pocket costs for services through high deductibles or copayments.
5. Capacity - The capacity problems of group practice HMOs participating in a guaranteed issue environment should be recognized.
6. Reinsurance - Participation in reinsurance pools, if established, should be voluntary for carriers which assume full financial risk for their members.
7. Mandated Benefits - Some relief from the extensive array of current state mandated benefits may be appropriate.²

CONCLUSION

Mr. Chairman, we recognize that some aspects of the communities we serve and of the policies governing our demonstration project clearly are unusual. However, we believe our

² State mandated benefits in New York, Florida and New Jersey are respectively: 26, 19, and 13.

overall experience is not unique and our recommendations are applicable to other settings and communities. Well managed prepaid group practice plans in very disparate geographic areas and communities are reporting similar experiences providing comprehensive benefits to small businesses and to previously uninsured persons. We offer our experience and our view that reforms can be enacted to address the problems your Committee has identified. We hope to continue to work with you as you strive to find equitable and affordable solutions to making health care available to all.

Chairman STARK. Thank you.
Mr. Van Valkenburgh.

**STATEMENT OF LEE VAN VALKENBURGH, SENIOR DIRECTOR,
PUBLIC AFFAIRS, CAPITAL BLUE CROSS, HARRISBURG, PA**

Mr. VAN VALKENBURGH. Thank you, Mr. Chairman. I am Lee Van Valkenburgh. I am senior director of public affairs of Capital Blue Cross in Harrisburg, PA.

As I think panelist after panelist has said earlier this morning, I want to stress that cost is the overwhelming reason that small employers do not provide health benefits.

Private insurers can do much to manage and restrain cost increases, but small group market reform should not be seen as a strategy to reduce costs. It is a strategy to ensure that every small employer can purchase private coverage that is fairly priced and won't be discontinued because of high claims volume.

In fact, all small employers in Pennsylvania already have access to community-rated insurance coverage because of the practices of Blue Cross and Blue Shield plans in that State. My particular plan has about 149,000 people covered in the market segment under 25 employees.

We believe any reform efforts should recognize that we do this, and preserve a system that is already working well in Pennsylvania and in some other States.

In previous hearings, you have heard how competition based on selecting rather than managing risks has led to practices such as screening out high-risk applicants or charging them substantially higher rates. While these practices and the resultant problems are common in many insurance marketplaces, not all insurers operate this way.

We in the Pennsylvania Blue Cross and Blue Shield plans, and some other States as well, still accept small groups at any time, regardless of health status, and we charge them community-rated premiums that are the same regardless of age, sex, or health status.

That is one reason, we believe, that Pennsylvania has the third lowest rate of the uninsured in the United States.

Chairman STARK. Do you medically underwrite?

Mr. VAN VALKENBURGH. No, we do not.

Chairman STARK. OK. And you have open enrollment basically and community rating?

Mr. VAN VALKENBURGH. That is right. The only requirements we have are participation requirements, requiring that—

Chairman STARK. A certain percentage of the employees sign up.

Mr. VAN VALKENBURGH. That is right.

Chairman STARK. OK, thank you. I just wanted to see that we are all talking about the same thing.

Mr. VAN VALKENBURGH. We are able to maintain these practices for a number of reasons. In the first place, we have low administrative costs. That means there is more available to pay benefits.

Second, we have a very high market share that enables us to spread the risk quite widely.

Third, we have negotiated over time hospital payment rates that represent significant savings over hospitals' charges or list prices.

And finally, we do truly believe that we should accept and manage risk rather than shift it, and that that is our job.

Chairman STARK. Pardon me if I interrupt you. It is my understanding that New York as a matter of legislation gets discounts for doing this. Ms. Wintringham, you get a discount because you have the same sort of standards that Mr. Van Valkenburgh is talking about by law.

In Pennsylvania, do you have to negotiate your hospital discounts or do you get legislative assistance?

Mr. VAN VALKENBURGH. No, we have no legislative provision—

Chairman STARK. So you have to do what they do in New York as a matter of law. You have to negotiate.

Mr. VAN VALKENBURGH. We negotiate.

Chairman STARK. OK.

Mr. VAN VALKENBURGH. In reforming the small group market, we generally support the reform approach that the Blue Cross and Blue Shield Association outlined earlier this month in testimony before you.

We believe States should have the flexibility to choose an approach that meets the needs of their particular environments. While a reinsurance approach may be appropriate in some States, we believe it is equally important for States to be able to choose approaches that do not rely on reinsurance.

Reinsurance hasn't really been tested in any State. It may prove difficult to regulate and costly to administer. The potential losses are unknown, and it could require additional funding, a sort of second-tier funding that I think people are concerned about.

The specific alternative that we support would assure that coverage is available to all small groups in the State through at least one insurer that voluntarily provides that coverage and meets other appropriate requirements.

This approach recognizes that in some States, insurers like my own already offer comprehensive coverage on a year-around, guaranteed issue, community-rated basis to small employers, and in these States, availability of health insurance is not a barrier to coverage—affordability is.

So such States should not be forced to establish reinsurance mechanisms to guarantee access that already exists. But to moderate practices throughout the small group market, it may be appropriate to require all insurers to meet standards such as rating and renewal requirements and to prohibit rejecting individuals from small groups.

Such changes would help assure that we can continue to act as a voluntary open enrollment carrier, as insurers of both first and last resort, if you will, because they would limit the practices that enable some carriers to cover only good risks and transfer bad ones to us.

Two additional points, if I might. Adequate enforcement is essential to the success of any of these approaches, and unless self-funded entities such as MUAS are brought under the direct regulation of the State, a large part of the market would be free to continue current rating and enrollment practices.

Second, to help hold down the cost of group coverage, we strongly support amending ERISA to exempt coverage sold to employers from State-mandated coverage requirements.

To conclude, in Pennsylvania we have a small group health insurance market that works. Coverage is available to all through the private market at community rates, and we hope that any small group market reform will recognize the unique concerns and situation of States and systems like our own. Thank you, Mr. Chairman.

[The prepared statement follows:]

**Statement of Lee Van Valkenburgh, Senior Director, Public Affairs,
Capital Blue Cross**

Mr. Chairman, and Members of the Committee, I am Lee Van Valkenburgh, Senior Director, Public Affairs, of Capital Blue Cross in Harrisburg, Pennsylvania. Capital Blue Cross, in conjunction with Pennsylvania Blue Shield, provides health benefits protection for more than 1,600,000 people. About 149,000 of these are in groups size 3 to 24.

Today's hearing has been called to focus on reforms in the small group insurance market. You have heard in your previous hearings on insurance market reform that cost is the overwhelming reason employers, especially small employers, do not provide health benefits. But another major concern in the small group market is that reasonably priced insurance products are often not available for groups that have very high-risk, high-cost employees.

In my testimony, I will comment on these concerns, and describe Capital Blue Cross' position on small group market reform. I would like to stress at the outset that small employers in Pennsylvania already have access to community-rated insurance coverage because of the practices of Blue Cross and Blue Shield Plans. We believe any reform efforts should recognize this achievement and preserve a system that is already working well.

Affordability

In considering why many small employers find health insurance unaffordable, it is important to understand that there are many components of health care cost increases, including practice patterns of providers, consumer demand for health care services, new technology, demographic changes, costs associated with medical malpractice and excess capital.

Capital Blue Cross has a long history of working to control costs directly. Our efforts include contract arrangements with hospitals that limit subscribers' liability while assuring that we pay only a reasonable amount for covered services. Our partner, Pennsylvania Blue Shield, has contract arrangements with physicians that limit payments to amounts that are reasonable and protect subscribers from "balance billing." In addition, we have pursued, over the years, aggressive programs to control unnecessary utilization and avoid the provision of services that are not medically necessary. Our focus on cost control has sharpened in recent years as overall health care costs have escalated. Currently, we use pre-authorization of non-emergency hospital services and surgery, concurrent utilization review, post-payment review and individual case management. To maintain quality and cost-effective care, we also have improved our strategies for negotiating payment rates and selecting providers in the increasingly important area of non-traditional providers such as substance abuse facilities, ambulatory surgical centers and rehabilitation hospitals. We continue to learn from our own and others' experience and seek new techniques to control costs. For instance, we are working with the Blue Cross and Blue Shield Association to control the cost of use of outpatient services, one of the fastest growing components of our costs.

We believe that through these and other measures there is much private insurers can do to manage and restrain increases in subscribers' costs. But even with the most aggressive efforts to use only the most efficient providers and to manage subscribers' use of the health care system, the cost of health care will remain out of reach for some employers, and in particular, small, marginally profitable employers.

Insurer Practices

In previous testimony before this Subcommittee, the Blue Cross and Blue Shield Association has described how the small group insurance market has evolved over time. In many states, price competition, driven by the rising cost of health care, has driven many insurers to be highly selective about the small groups they will accept or to weigh each small group's experience in figuring the group's rates.

Thus, competition based on selecting rather than managing risks has led to practices such as screening out or denying coverage to high-risk applicants and charging such applicants substantially higher rates.

Capital Blue Cross' Practices. While these practices and the resultant problems are prevalent in most insurance markets, not all insurers operate this way. Specifically, Blue Cross and Blue Shield Plans in Pennsylvania and some other states still accept small employers on a year-round, open enrollment, community-rated basis. That is, we accept small groups at any time of the year regardless of their health status and we charge them rates that reflect the underlying experience of our whole small group business -- a community rate -- rather than a rate that reflects the experience of individual small employers. While the individual market is not a topic of discussion today, I would like to add that we also accept individuals for coverage on a subsidized, continuous open enrollment basis and we community-rate this coverage.

It is in part because of the Blue Cross and Blue Shield enrollment practices that Pennsylvania has the third lowest rate of uninsured persons in the United States.

We are able to maintain these practices for several reasons:

- o Low administrative costs mean we can spend more of the premium dollar on benefits. Our combined administrative expenses with Pennsylvania Blue Shield are less than 7 percent. So the total cost to groups is lower.
- o We have a high market share -- about 53 percent of the total population in our service area. This enables us to spread risk more broadly without unduly inflating rates to good risk groups. We are, however, becoming concerned that competitor practices such as insuring only the healthy members of small groups, as well as the rise of self-funding in groups as small as 75 will erode our ability to spread risk.
- o Thanks to several factors -- large market share, prompt and direct payment, comprehensive benefits and the way we minimize uncompensated care by making coverage broadly available -- we have been able to negotiate inpatient hospital payment rates that represent significant savings over "list price" -- savings that we pass on to our customers. These savings help offset the costs associated with the high-risk cases we insure.
- o Finally, we can maintain these practices because we choose to do so, and we look for ways to make them work. We truly believe that accepting and managing risk, not shifting it, is our job.

One final note on this subject. We do have an exemption from state premium taxes. This is not, however a significant factor, because we surcharge all large and even small groups to subsidize our individual and Medigap subscribers.

Capital Blue Cross joins with the Blue Cross and Blue Shield Association in the belief that small group market reforms are necessary to replace competition based on risk selection with competition based on administrative efficiency, service, and ability to control costs.

Specifically, we support the Blue Cross and Blue Shield System's recommendations to:

- o Assure that small employers have access to private insurance, regardless of health status, occupation or geographic location;
- o Assure that states have a range of options to choose from in providing for the availability of private insurance to small employers;
- o Assure that small group coverage is provided at fairly established rates;
- o Assure that no small employer is dropped from coverage because of poor claims experience;
- o Assure the adequate, effective enforcement of all insurer requirements; and
- o Assure the availability of lower-cost products.

I'd like to focus my remaining remarks on Capital Blue Cross' position on how to assure small employers access to private insurance. In general, we believe that states should have the flexibility to choose an approach that meets the needs of their environments. Those approaches may include a requirement that all insurers accept all small groups with some sort of private reinsurance mechanism, options that do not rely on reinsurance or other approaches deemed appropriate by the state.

While a reinsurance approach may be appropriate in some states, we believe it is equally important for states to be able to choose approaches that do not rely on this approach. Reinsurance has not been tested in any state. It may prove difficult to regulate, costly to administer and unfair to some insurers. In addition, the losses are unknown and could require additional funding.

The alternative that we specifically support would assure that coverage is available to all small groups through at least one insurer that voluntarily provides such coverage and meets other appropriate requirements.

This approach recognizes that in states like ours, an insurer (or insurers) already offer comprehensive coverage on a year-round, guaranteed issue, community-rated basis to small employers. As I described earlier, Blue Cross and Blue Shield Plans in Pennsylvania and some other states offer year-round "open enrollment" for all their small group products and charge a single rate for all small groups in an area. In these states, availability of health insurance is not a barrier to coverage -- the primary barrier is affordability. Thus, rather than devoting scarce resources to address an availability problem that does not exist, states should be able to devote their resources to more pressing needs, such as making coverage more affordable.

In addition, such states should not be forced to establish reinsurance mechanisms that might be required if all insurers had to accept high-risk small groups. Reinsurance programs would be expensive and would raise the costs of health insurance premiums in these states. They also are untested, administratively complex and may be difficult to regulate.

However, to moderate practices throughout the small group market, it may be appropriate to require all insurers to meet standards such as rating and renewal requirements and a prohibition against rejecting individuals from small groups.

Such changes should assure that we can continue to act as a voluntary open enrollment carrier -- as the insurer of both first and last resort, if you will -- because the rating and other requirements limit the practices that enable some carriers to cover only good risks while transferring bad ones into our small group or individual books of business. In this same vein, Pennsylvania Insurance Commissioner Constance Foster has addressed this issue in a ruling that prohibits insurers from excluding individuals from a group by reason of their health status -- a ruling that has been upheld by our Commonwealth Court. Insurers in Pennsylvania must, therefore, accept entire groups -- or forego the business.

Before concluding, I would like to stress two additional points. First, adequate enforcement is essential to the success of any of these approaches. Of particular importance is the inclusion of self-funded Multiple Employer Welfare Arrangements (MEWAs) and out-of-state trusts in any reform measures. In some states, these entities provide coverage to a substantial segment of the small group market. If they were not subject to market reforms along with other insurers, more and more of the insured small group market would be encouraged to move to these self-funded, unregulated entities, thereby, rendering any reform largely meaningless.

We also support enforcement measures that would minimize insurer gaming. These measures could include a requirement that all entities selling small group coverage register with the state insurance commissioner and publish a list of these entities for distribution to small employers in the state.

Second, in response to concerns about the high cost of small group coverage, we strongly support amending ERISA to exempt coverage sold to small employers from state-mandated coverage requirements. We believe that insurers have a responsibility for developing lower-cost products for small employers, but under present state laws, that is often hard to do.

Conclusion

To conclude: Pennsylvania has a small group health insurance market that works. Coverage is available to all through the private market at community rates. We think that others could learn from our system. But the system does require some delicate balancing. So we hope that any small group market reform will recognize the unique concerns of states and systems like ours.

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Chairman STARK. Thank you.
Mr. Bolnick.

**STATEMENT OF HOWARD J. BOLNICK, PRESIDENT, CELTIC LIFE
INSURANCE CO., CHICAGO, IL**

Mr. BOLNICK. Thank you, Mr. Chairman. My name is Howard Bolnick, and I am a health actuary and president of Celtic Life Insurance Co. in Chicago.

Celtic is a major provider of health insurance for businesses with from 1 to 10 employees—the very small end of the marketplace. But we are representative of mid-size commercial insurers who focus on the small group marketplace.

In recent years, I have spent much of my time learning about how businesses use their health insurance. I understand the need for change. As a result, my company has modified its business practices. I have also worked for insurance reform, most notably with the Health Insurance Association of America and the National Association of Insurance Commissioners.

My written testimony describes the interaction between small business' insurance needs and insurers' standard actuarial risk management practices. Analyzing these sometimes complex interactions helps to explain why insurers operate in ways that are sometimes viewed as dysfunctional, how technically sound reform can change insurers' practices, and what effects reform has on the cost and availability of health insurance.

I believe that carefully designed reform is needed, but I also know that technically flawed reform will increase costs and decrease availability of health insurance. This will simply hurt the very people we all want to help.

I would like to make four major points about reform: Point one is that even carefully designed reform will not significantly increase access to health insurance. Anecdotal evidence is used to imply that insurance company practices create a large portion of the working uninsured. Health underwriting, competitive rating strategies, and breaks in continuity of coverage are, in fact, barriers to access. However, these barriers are responsible for only a small portion of the problem.

For example, in a recent study by the University of Minnesota, only 2½ percent of the uninsured in their State were refused coverage due to poor health. Helping these Americans by opening access to insurance is certainly worthwhile, but studies consistently show, and you have consistently heard today, that cost, rather than access, is the real culprit.

Point two: removing barriers to access will increase the cost of health insurance and may actually increase the number of working uninsured. Open access is not cost free. There is simply no magic in insurance risk spreading. Common sense dictates, and actuarial analysis confirms, that adding disproportionate numbers of unhealthy and therefore costly people to an insurance pool must raise costs.

Chairman STARK. Let me ask you this, though. Let's assume that you are in an area, as Mr. Van Valkenburgh is, where you have

half the business in his book. You'd be paying for the high-cost uninsured now, right?

Mr. BOLNICK. Yes.

Chairman STARK. Because the hospitals are kicking up their rates for uncompensated care. So in a social sense, your customers are going to pay for the uninsured. It would seem to me that we would be more efficient if we had them in the insurance pool on the theory that they would get proper care sooner. Does that make sense to you economically?

Mr. BOLNICK. Yes, and my argument is more watching what happens when you segment the market and lay onto small business certain obligations.

Chairman STARK. I hear you.

Mr. BOLNICK. OK, so it is a very different thing than disagreeing overall. But I think there are a lot of things that happen when you start focusing on the small business market that you have to be careful about in insurance reform.

Continuing now, another issue that has come up is replacing competitive rating strategies with community rates. I believe that this creates new indirect taxes. Raising premiums for younger people and rural businesses to subsidize older people and urban businesses really increases the costs on people already most likely to be uninsured.

Higher costs increase an already formidable hurdle for many vulnerable small businesses. More people could lose their health insurance as additional businesses drop coverage than those few who gain access through removing barriers. I can easily envision ill-conceived reform creating 1 to 2 million new uninsured Americans.

Point three: reform triggers unpredictable dynamics—and this is the point, sir, that we were just talking about briefly. Reform creates new opportunities for potentially counterproductive choices.

For example, unhealthy workers denied employment in large businesses due to the growing use of health screening could choose to access small business health insurance. Large businesses with unhealthy participants could choose to dump these costs onto small businesses.

On the other hand, healthy small business employees could choose to flee to cheaper, still medically underwritten insurance that may be left untouched by reform.

These dynamics could unintentionally disrupt or even destroy the very market that reform is intended to help.

You seem to have a question.

Chairman STARK. Yes, I was just wondering. Do you write in New York?

Mr. BOLNICK. no.

Chairman STARK. You don't?

Mr. BOLNICK. No.

Chairman STARK. I am just wondering. In New York, wouldn't it be possible for one of your potential clients to dump their sick or older employees into Blue Cross, or into HIP's New York plan?

In other words, where you have people who operate with no underwriting and community rating, the opportunity for employers to dump exists today.

Mr. BOLNICK. That is true.

Chairman STARK. I should think you would get a license in New York. That sounds like a hell of a good deal. [Laughter.]

Mr. BOLNICK. There are a few other problems involved with that.

My last point, and I am sorry I am out of time, but I hope you——

Chairman STARK. Just go right ahead. There is nobody else waiting. [Laughter.]

Mr. BOLNICK. Reform is a complicated technical task. State experimentation, I believe, offers the best chance for developing and demonstrating effective reform. Dedicated and knowledgeable people are uncovering technical complications with reform proposals. These types of concerns are being increasingly aired before congressional committees.

Reform needs to be tested before anybody can vouch with confidence for their ability to solve more problems than they create. State experimentation, motivated or compelled, if necessary, by Congress is the best way to proceed for the next few years.

In conclusion, health insurance reform is a politically appealing and modestly helpful incremental step. However, it must be done carefully. Overly simplistic, untested ideas simply set in motion dynamics that cause more problems than they solve.

Thank you, Mr. Chairman. I would be happy to answer more questions of yours.

[The prepared statement follows:]

Statement of Howard J. Bolnick, FSA, MBA, President, Celtic Life Insurance Co.

Small Business Health Insurance Market Structure:
Improving Prospects for Effective Reform

There is agreement that some practices in the small business health insurance market add to the problem of access to health insurance. This has lead to calls for reform. A number of options are being debated. Choosing among them requires an understanding of the principles upon which insurance markets are structured and how this structure affects insurer and consumer behavior. By uncovering these principles, and comparing them to the existing small business market structure, various reform options, then, are examined for their potential effectiveness.

State governments and the federal government have become increasingly interested in finding ways to bring an estimated 31.5 million uninsured people into the mainstream of American health care.¹ Hawaii, Massachusetts, and Connecticut, for example, have implemented public and private sector programs to reduce the ranks of their uninsured populations. Other states, such as New York, New Jersey, and California seem committed to tackling the problem and are engaged in political debate leading potentially to new legislative programs. Most other states are studying options or pursuing limited solutions to the problem.

The federal government has been a major catalyst for change. Numerous Congressional hearings and reports culminated in formation of the Pepper Commission which presented its Final Report in September, 1990.² More than any other single report, the Commission's work has become a focal point for those interested in making progress towards universal access to affordable health care in America. However, a close vote on the Commission's health care recommendations (approved 8 to 7) and the wide range of written opinions expressed by the Commissioners, point to the lack of a workable consensus on how to solve our nation's health care problems.

There was, though, widespread agreement among the Commissioners that some practices in the small business health insurance market add to the problem of access to health insurance, particularly among small businesses that employ fewer than 25 employees. Recommendations made in the Final Report to reform those practices, which seem to be causing problems, are seen as a politically appealing incremental step in solving America's health care problems.

This paper explores the critical role that private sector reforms have in improving small business access to affordable health insurance. Reform is needed. But, in a market as large and complex as this, changes aimed at improving its operation may be ineffective or have unintended consequences. By focusing on the structure of the existing small business health insurance market, and examining how and why it operates in ways that contribute to the number of working uninsured, the efficacy and consequences of various reforms can be better understood.

Defining the Problem: A Closer Look at Small Businesses and Their Health Insurance.

According to the 1988 Current Population Survey (CPS), 23.8 million of the 31.5 million uninsured Americans lived in families headed by full-time or part-time workers. Of these

23.8 million working uninsured, there were 14.4 million workers and 9.4 million dependents. Slightly over half of the total, or 7.3 million workers, are employed in small businesses with fewer than 25 employees.³ Clearly, large numbers of the working uninsured are affiliated with small businesses.

These statistics do not fully describe the problem. Small businesses are even less a source of health insurance for their employees than is implied by data focusing solely on the working uninsured. As Figure 1 shows, small businesses directly provide only 32.0%, or 10.3 million workers, with small group health insurance. An additional 24.8%, or 8.3 million workers, have health insurance provided through sources other than their employer. Much of this coverage is individual health insurance sold to employees of small businesses with or without direct employer subsidies. It is virtually impossible to know how much of this is truly employer sponsored coverage. So, small businesses actually sponsor health insurance for between 32.0% and 56.8% of their workers. Larger businesses (those that employ 25 or more workers) cover 72.2% of their workers.

Following up on these research findings, the news media has increasingly written about the difficulties small businesses have with their health insurance.⁴ At the same time, Congress, state legislators, and state insurance regulators have been receiving complaints from small businesses about large premium increases, an inability to purchase new or replacement coverage, and terminations of existing coverage. These stories and complaints have raised serious questions about how the small business health insurance market operates.

Having received this research and anecdotal evidence, the Pepper Commission opined:

"Even though most small firms provide insurance to their workers, large numbers do not--increasingly because they are disadvantaged in the insurance market....Insurance practices that make it hard for small employers to obtain coverage are the byproduct of today's competitive market."⁵

Even some politicians and health policy analysts sympathetic to the insurance industry have begun to listen to critics who argue that health insurers' business practices are the primary problem.

The Pepper Commission and other analysts cite the following insurance practices as the specific causes of small businesses' low participation in the health insurance market.

- The decline of community rated health insurance and introduction of rating strategies which differentiate rates by the health status and claims experience of employees (i.e., "duration" and "tier" rating practices).
- The inability of insurers to spread risk over a large number of employees.
- Competition among insurers to offer coverage only to the best risks.
- Abusive use of contractual insurance restrictions, such as terminating coverage and imposing exclusions of pre-existing health conditions.⁶

These descriptions of market practices are real to a greater or lesser extent. However, they are only symptoms of underlying structural problems. A more thorough understanding of the small business health insurance market structure is needed in order to properly design effective reform strategies.

Clear Expectations: A Small Business Health Insurance Market That Operates Like a Social Insurance System.

There are now calls for legislation and regulation to reform the small business health insurance market. For example, the Pepper Commission recommends that:

insurers be required to guarantee acceptance of all small businesses wishing to purchase health insurance (i.e., no health underwriting allowed),

full benefits be made available immediately (i.e., no pre-existing condition limitations allowed),

limits be placed on premium differentials based upon certain actuarial risk characteristics (i.e., no tier and duration rating or unacceptable risk classification rating allowed).⁷

These legislative recommendations are explicitly intended to ensure that all small businesses who seek insurance will be able to find it, and businesses with high risk individuals cannot be priced out of the market.

The Committee on Social Insurance Terminology of the American Risk and Insurance Association developed a definition of social insurance systems with eight criteria.⁸ Among these criteria, universal coverage and rating formulas incorporating cross subsidies among risks with different underlying actuarial costs are characteristics of a social insurance system.

Social insurance systems are usually thought of as public programs: for example, Medicare and Medicaid. Private insurance systems can also be social insurance systems. State workers compensation systems are relevant examples in widespread use today. Many analysts have also suggested that the large business health insurance market, while not a social insurance system, operates as if it were one and should be emulated by the small business market. However, for reasons discussed below, the large business market is a unique private health insurance market which does not serve as a useful model for how the small business market could operate.

There is general agreement, even within the insurance industry, that reforms need to be devised to help the small business market operate as much as possible like a social insurance system. To help achieve this goal, we will explore the principles upon which social insurance systems are built. By uncovering these principles, and comparing them to the existing small business market structure, we can then examine the potential effectiveness of various reform proposals.

Risk Management Problems and Insurance Principles Underlying Effective Social Insurance Systems.

In an effective social insurance system, two risk management problems inherent in all competitive insurance markets must be overcome. First, tendencies toward biased selection must be controlled. Second, selecting better risks as a form of price competition among insurers must be significantly reduced or eliminated.

Insurers is used to refer to all institutions making health coverage available to small businesses, including commercial insurers, Blue Cross and Blue Shield plans, self-insured multiple employer welfare associations (MEWA), managed care plans, and public programs. Insurers participating in the small business health insurance market underwrite either small group health insurance on businesses or individual health insurance on employees.

Biased selection occurs in markets structured with an information imbalance between buyers and sellers. In these markets, buyers can take advantage of superior knowledge about their own risk characteristics to affect the timing of insurance purchases. This is known as the "free rider" problem and is caused by people postponing insurance purchases until an immediate need arises.

A moderate degree of biased selection either makes coverage less affordable by increasing the average claim per market participant, or, less available if risk management tools (e.g. health underwriting) are used to compensate for an information imbalance. Severe biased selection increases average claims per capita so much that buyers and insurers who might otherwise participate in the market abandon it altogether.

Unchecked competition among insurers can also have deleterious effects. Voluntary private insurance markets are often characterized by intense price competition. Insurers can lower premiums by using one or two generic strategies: segmenting the market and offering coverage to disproportionate numbers of better risks (e.g., health underwriting), or, finding competitively superior ways to reduce claims for all insureds (e.g., managed care). In many markets, including health insurance markets, a small number of people account for an inordinately large portion of losses. In markets with skewed distributions of losses, insurers find that selecting better risks is an effective strategy to enable them to offer competitive prices to buyers.

Biased selection and competition for better risks each undermine a market's ability to function as a social insurance system. There are four insurance principles that must be met to structure a market free of these basic problems. Two principles describe a market's covered population. Two other principles describe a market's financial structure.

Eligibility and Participation Principles: Risks eligible for coverage must be a well defined population, and, all eligible risks must participate.

If the insured population is smaller than the market population, biased selection can occur. Biased selection occurs when better risks do not participate, thereby raising the per capita insured claims for those eligible members who do participate.

Choice of participation upon initial eligibility for coverage introduces initial biased selection. Buyers, with their superior knowledge, may choose to delay making a purchase until the need for coverage arises. Once covered, choice of continued participation may introduce ongoing biased selection. Ongoing biased selection occurs if market participants drop coverage once their risk of loss diminishes. Initial or ongoing biased selection cause an insured population that is worse than the average risk.

To be effective a social insurance system must eliminate choice of whether to be covered or not. When everyone is covered, the per capita insured claims are forced to be

equal to the average claims in the market population. Choice is eliminated by providing eligibility only to a population in which membership is beyond individual control, and, by structuring financial incentives or legal obligations so that every eligible risk also participates.

Intermediary Principle: The market's risk must be borne by a single insurer. Multiple insurers serving the same market introduce two potential problems: financial biased selection and competition for better risks.

Biased selection can occur within an otherwise well structured market. Choice among insurers may introduce financial biased selection, which is experienced by only the subset of all the insurers being selected against. Competing insurers, by definition, each serve a population smaller than that of the entire market. If, for price or other reasons, better risks consistently choose some insurers over others, financial biased selection occurs. Insurers with more of the better risks, then, have lower claims in their insurance pools than those insurers with more of the worse risks.

Competition among insurers also introduces the opportunity and, quite often, a necessity to select better risks. If better risks seek low prices, then many insurers respond to these demands by segmenting the market based upon assessable criteria which accurately predict different underlying actuarial costs and offering the better risks more favorable contract terms and prices.

A market structured with a single insurer eliminates these problems. Without competitors, financial biased selection cannot occur. The sole insurer need be concerned only about biased selection at the market level which could be caused by violations of the Eligibility or Participation Principles. In addition, since its charge is to serve the entire market, a sole insurer cannot affect prices by market segmentation. It affects prices only by managing losses.

Equity Principle: Individuals or groups within a social insurance system must be willing to equitably cross subsidize each other's claims regardless of their own risk characteristics. Even when a single insurer covers a well defined population, individuals or groups who feel that their premium is unfair can often take steps that will destabilize the market. Better risks demand rating formulas that reflect their lower claims and unwinding existing cross subsidies. Or, they find other ways to avoid paying a fair share, such as dropping their insurance, moving to markets offering substitute coverages, self-insuring, or, if possible, applying political pressure for change.

To avoid these problems, the market usually must be structured to fund losses through either indirect means, such as tax revenues, or direct subsidies and tax favored contributions. These approaches break the direct link between costs and benefits and undermine many buyers' natural concerns about cross subsidies and underlying costs.

The structure of both public and private insurance markets can be analyzed in accordance with these four social insurance principles. In some instances, a market is so well structured that all four principles are naturally satisfied. An example of this is the Medicare Old Age Program. In some cases a more typical private market, which does not naturally meet these principles, can be structured by buyers and sellers to work in many ways as if it were a social insurance system. Experience rating in the large business health insurance market is an example. In still other instances, however, the market cannot be properly

structured to avoid violating one or more of the principles. This happens in the small business health insurance market. In these markets, risk management tools must be used to compensate for violations of social insurance principles.

Each example of these three types of market structures is more fully discussed below. Chart 1 summarizes how each market is structured around these social insurance principles.

Medicare Old Age Program---A Naturally Structured Public Social Insurance System.

Prior to the introduction of Competitive Medical Plans in 1982, Medicare was an example of a naturally well structured social insurance system. That is, all four social insurance principles were satisfied by market structure.

Eligibility and Participation Principles. All Americans age 65 and over are eligible for Medicare. Individuals, then, have no choice of whether or not they become eligible. Medicare, by definition, covers a well defined population.

Participation of eligible individuals in Medicare Part A is automatic and without direct premium to those enrolled. Medicare Part B participation, while voluntary, is so heavily subsidized by general revenues that almost all eligible individuals join. The population participating in Medicare Parts A and B is not significantly different from the eligible population. So, neither initial biased selection nor ongoing biased selection are problems.

Intermediary Principle. Until 1982 when CMPs were introduced, all Medicare participants received their coverage from a single insurer, the federal government. This structure allowed no opportunity for financial biased selection or competition for better risks to occur.

Equity Principle. Medicare is heavily subsidized by the federal treasury and by workers under age 65. While direct costs for medical benefits are rising rapidly, there is little evidence that this is currently a barrier to enrollment or to continued coverage. The covered population has no incentive to undermine Medicare in search of greater personal equity.

Because the market was structured as required by the four social insurance principles, the Medicare old age program was a natural social insurance system prior to introduction of CMPs. All forms of biased selection and price competition were effectively removed by virtually universal participation of a well defined eligible population, a single insurer, and large tax subsidies. Medicare was able to operate in a manner fully consistent with its social goals of making coverage universally available at affordable prices.

This well structured system was somewhat disrupted in 1982. Competition among insurers was introduced with Competitive Medical Plans (CMP). For the first time, insurers other than the federal government were allowed to compete for Medicare participants. This violated the Intermediary Principle. Predictably, charges arose that CMPs compete for better risks and do not focus solely on providing low cost care to Medicare participants.⁹ The validity of these charges and cost implications, if any, are still being debated. The introduction of CMPs demonstrates, though, that market structure can effect market behavior.

Large Businesses---A Private Market Structured to Operate Like a Social Insurance System.

Following World War II, the large business market began to change from a single risk pool using community rates, to one in which each business became, in effect, its own "mini-market". Experience rated contracts used to fund health insurance coverage by large businesses (usually businesses with at least 100 to 200 employees) are examples of the private sector's ability to structure a market to operate in many important ways like a social insurance system. This structuring does not create a true social insurance system. However, it does provide a structure in which the four social insurance principles are generally met by each large business and the need for compensating risk management tools is minimized. This makes coverage widely available to employees and their dependents.

Eligibility Principle. An insurance pool structured to cover only employees of a single large business would seem to violate the Eligibility Principle by covering only a small portion of all employees working for large businesses. The integrity of large businesses' hiring practices is the key to compensating for this apparent violation.

It is highly unlikely that a large business will hire workers solely to obtain needed health insurance. Rather than providing easy access to health insurance, businesses are actually increasingly engaged in hiring practices that serve as proxies for health underwriting and effectively avoid initial biased selection.

Basing eligibility for insurance on employment has a meaningful risk selection effect. At a minimum, an "actively at work" requirement screens out those unhealthy people who are unable to work full-time. At a maximum the employment process can be used to screen out employees (or their dependents) who appear to be at risk for large medical expenses. A survey by the National Institute for Occupational Safety and Health found that the percentage of businesses requiring new employees to pass medical screening exams increased from 38.5% in the early 1970's to 49% in the early 1980's. Other studies found large increases in the use of genetic testing, drug use testing and AIDS antibody testing.¹⁰

Most large businesses have little material exposure to ongoing biased selection. Normal employee turnover is not a problem unless for some reason a significant portion of ongoing employment decisions revolve around a need to continue health insurance. In large companies with modest to moderate turnover, the insured population is stable enough that ongoing biased selection is unlikely to occur.

Actively-at-work requirements, increasing use of health screening, and relatively stable workforces create a high level of integrity in the eligible populations of large businesses. This effectively structures the market so that the Eligibility Principle is met.

Participation Principle. Large businesses are also able to structure effectively their insurance pools to compensate for potential violations of the Participation Principle. Employers' subsidy of health insurance premiums on a tax favored basis helps assure high participation. Surveys show that large businesses pay, on average, over 80% of the total cost of health coverage.¹¹ This subsidy, combined with a strong competitive necessity to offer health insurance, results in fully 86.9% of workers in businesses with 500 or more employees being covered as either employees or dependents (see Figure 1).

Since employee and dependent participation in health insurance is voluntary, premium subsidies can reduce, but not eliminate biased selection. To control against

meaningful residual problems, insurers (in this case the businesses themselves) have devised widely used risk management tools. For example, employees and dependents who do not enroll at the time of hire are usually subject to pre-existing condition limitations or must submit evidence of insurability. Many businesses also use short waiting periods to guard against employees accepting jobs mainly to obtain health insurance to cover known medical problems.

Intermediary and Equity Principles. Large businesses have a choice of insurers willing to underwrite their risk. This clearly violates the Intermediary Principle. However, the market is fundamentally changed by the willingness of businesses to experience rate or self-insure their own claims. Experience rating is essentially an agreement to pay for one's own claims. Experience rated and self-insured plans unwind all cross subsidies among large businesses. Businesses have no intermediate to long term source to pay claims other than their own financial resources. The business, in effect, becomes its own insurer in a market with no other competitors. This meets the Intermediary Principle. It also eliminates the search for greater equity causing the Equity Principle to be met.

Insurers writing large group health insurance are unable to compete by offering promises to lower their prices by unwinding cross subsidies. They are limited to compete mainly on services, including services aimed at helping business clients reduce claims. Thus, financial biased selection and competition for better risks is structured out of the market.

The ability of large businesses and insurers to structure the large business health insurance market to accommodate their needs without violating the social insurance principles is an example of the vitality and complexity of private insurance markets. This effective market structure is possible because of:

The integrity of businesses' employment practices,

Relative stability of most businesses' covered populations,

Employers' subsidy of the cost of their employees' health coverage,

A willingness to pay their own claims, and

A competitive necessity to offer health insurance to their employees.

This allows large businesses to function in a manner consistent with that expected of a social insurance system: providing widespread access to affordable health insurance.

However, this market falls short of reaching the social goal of universal access in a number of subtle, but significant ways.

Large businesses create barriers to entry through hiring practices that require workers to be active and productive, and increasingly use a variety of health screening tests.

Risk management tools such as pre-existing condition limitations, waiting periods, definitions of eligible dependents, and termination of coverage provisions, which are used to assure the integrity of the covered population, make health insurance unavailable to some employees and dependents.

These restrictions help create a class of "residual risks" which must seek health insurance coverage in other private markets or become uninsured. If there are enough residual risks and they find their way, in disproportionate numbers, into the small business health insurance market, then, large business insurance practices may materially affect affordability and, even, viability of health insurance for small businesses.

Small Business Health Insurance---A Market In Which Social Insurance Principles Fail.

Market structures which minimize biased selection and competition for better risks do not exist in the small business health insurance market. Small group and individual health insurances are sold to an ill defined and unstable population with far less than universal participation, served by a large number of competing insurers, with better business risks constantly seeking low cost alternatives.

Eligibility and Participation Principles. Small businesses are neither a well defined nor a stable population. Surveys show that small businesses are characterized by high employee turnover and low market participation. Employee turnover is significantly higher in small businesses, with 27.1 annual separations per 100 employees, than in large businesses, with 15.4 separations per 100.¹² Data from the 1988 CPS show that of the 33.4 million employees working in businesses with fewer than 25 employees, only 10.7 million, or 32.0% of these workers are covered by employer sponsored health insurance and as many as 8.3 million, or 24.9%, by individual health insurance (see Figure 1). Low participation and high turnover create an enormous opportunity for biased selection.

While there is no published research on the incidence of biased selection, insurers know from experience that small businesses can easily be used solely for obtaining health insurance. Forming a small business, or adding unproductive people simply to obtain insurance are both potential and practiced abuses.¹³ To compound these problems, small businesses, much like individuals, often have superior knowledge about the health of their employees and dependents. This knowledge allows buyers to judge their need for health insurance and time their purchases accordingly. Unlike the large business market, employer health screening, integrity of hiring practices, and high participation in health insurance, cannot be relied upon to avoid small businesses capitalizing on their superior knowledge thereby causing initial biased selection.

A high risk of ongoing biased selection also exists. Industry measures of the turnover of small group health insurance coverage show that it is generally much higher, at 25% to 50% per year, than small business employment turnover, at 27.1% per year (see above).¹⁴ This churning, when coupled with the administrative difficulty inherent in policing the dissolution of businesses and employee separation from service, creates the potential for worse risks to continue needed insurance coverage beyond the terms of their insurance contract. Once again, while there is no thorough research to demonstrate the point, insurers are well aware of these abuses.

Some analysts suggest that a stable market would be created by using Multiple Employer Trusts (METs) or associations to aggregate large numbers of small businesses into risk pools that can then operate like large businesses. METs and associations are widely used by insurers and even non-

insurer plan sponsors (e.g. some Chambers of Commerce). However, high turnover, abusive employment practices, and superior health knowledge, which are characteristic of small businesses choosing to participate, remain unchecked in a pool. Unlike a large business, which can effectively create a stable covered population, aggregating large numbers of small businesses, each with their own ill defined population, into METs or associations does not create a well defined population.

The small business health insurance market cannot avoid violating both the Eligibility and Participation Principles. It is very difficult to control biased selection by structural changes alone.

Intermediary and Equity Principles. The small business health insurance market is served by a large number and wide variety of insurers. Coverage can be obtained through different legal vehicles including METs, discretionary group trusts, associations, Taft-Hartley plans, MEWAs, and HMOs using both small group and individual insurance contracts. The number of choices available to a single small business is quite large. This violates the Intermediary Principle.

The high cost of health care in America means that fairly priced health insurance is a real burden, particularly to the many financially vulnerable small businesses. Research has consistently shown that cost is the single most important reason cited by small businesses for not offering health insurance.¹⁵ There is no subsidy for small business owners, other than any available tax deduction of premium, and self-insurance is not a viable option. One of the most effective options available to small businesses to reduce their health insurance costs is to demand rating and underwriting strategies from insurers that unwind cross subsidies. This violates the Equity Principle.

These violations have predictable consequences on market behavior. The market is characterized by businesses churning their coverage among competing insurers in search of low cost alternatives. This, in turn, increases administrative costs, causes financial biased selection and competition among insurers for better risks.

The small business market structure fails to meet all four social insurance principles. Unlike the large business market, in which structural changes are able to adequately compensate for violations of these principles, the small business market has been unable to develop a structural solution for its fundamentally unfavorable market characteristics.

Risk Management Tools: How The Private Sector Compensates for a Market Structure That Violates Social Insurance Principles.

Risk management tools are universally used by insurers, implicitly or explicitly, to compensate for violations of social insurance principles. Faced with a combination of initial, ongoing, and financial biased selection in the small business health insurance market, insurers have adopted appropriately designed risk management tools. These tools have proven effective in other similarly structured voluntary private insurance markets (e.g., individual life insurance).

In reality, small group insurance is "group" insurance in name only. There is little or no difference between the biased selection problems faced by insurers selling small group health insurance and individual health insurance. There are also quite meaningful similarities between the types of biased selection problems faced in health

insurances and individual life, or other voluntary personal insurance products. In all voluntary markets, an appropriate selection process is the risk management tool used to compensate for initial biased selection. Health underwriting is a widely used tool filling this role for small group and individual health insurances.

An insurer pricing its small group health insurance is faced with a complicated pattern of claims.¹⁶ Effective health underwriting, which assures the insurer that seriously ill risks do not enter its risk pool, results in a "select period". In this phase per capita claims are better than the average. As the value of underwriting wears off, the select period is replaced by an "anti-select period". During this phase, ongoing biased selection and financial biased selection cause per capita claims to become worse than the average.

Faced with patterns in which claims increase relative to the average with time in many voluntary markets, actuaries developed rating strategies designed to attract and keep better risks while equitably rating worse risks. Individual life insurers use "select and ultimate" rating strategies. Personal automobile insurers use "merit" rating systems. Drawing from these markets, actuaries devised "duration" and "tier" rating strategies.

Duration rates vary solely with time. They are initially low to pass along to buyers the value of lower claims arising from health underwriting and any pre-existing condition limitations. Over time, rates increase to compensate for the wearing off of the select period and the onset of the anti-select period. This causes rates by duration to increase more rapidly than average rates.

Tier rates vary according to claims experience of each small business. They are used to differentiate small businesses into a limited number of rating "subpools". Small businesses with better risks are offered lower rates to keep them from changing insurers. Worse risks are charged higher rates. But unlike true experience rating in which each risk group pays its own claims, the prices among tiers are usually narrow enough that businesses with better risks still cross subsidize businesses with worse risks.

Real Versus Perceived Problems in the Small Business Health Insurance Market.

While these health underwriting and rating practices are actuarially sound and well suited for the small business health insurance market, they clearly give rise to public concerns about market practices. Community rating has been replaced with rating strategies that unwind cross subsidies. Health underwriting makes access to coverage difficult for some and impossible for others. Price competition focuses some insurers as much on selecting better risks as on controlling claims. Some insurers may even take advantage of the situation by making abusive use of various risk management tools.

Insurers and small businesses have been unable to create a health insurance market structure that can operate as if it were a social insurance system. This failure occurs for a number of reasons.

Problems Affecting Eligibility and Participation Principles.

There is neither adequate integrity in the small business employment process nor sufficient stability in their covered population to control for biased selection.

Low market participation creates many opportunities for biased selection.

Small businesses are the targets for "dumping" unhealthy residual risks from other markets that have their own, often subtle, barriers to entry.

Problems Affecting Intermediary and Equity Principles.

There is little willingness among small businesses with better risks to cross subsidize businesses with worse risks.

Regulation and market behavior differs widely among various types of insurers and health insurance contracts sold to small businesses or their employees.

There is intense price competition among insurers to provide health coverage to small businesses.

Nevertheless, through use of well established risk management tools, insurers have created small group and individual health insurance coverages that are widely, but not universally, available to small businesses.

Opening Up the Small Business Risk Pool: The Potential Cost of Biased Selection.

A common theme of reform proposals is the need to guarantee small businesses access to health insurance. Little critical thought, though, has been given outside the insurance industry to the potential cost of guaranteed access.

Small group health insurance is the sole focus of reform proposals. Individual health insurance is not included because: its role in providing coverage to small businesses is not widely recognized, it is very difficult for insurers to define and police the distinction between employer sponsored individual coverage and true unsponsored coverage, and serious problems arise when attempting to layer a new regulatory system on top of existing, extensive state individual health insurance regulations.

Data presented in Figure 1 shows that 10.7 million workers participate in small group health insurance. This population is only 32% of the 33.4 million employees of small businesses, and only 9.4% of the total 114.1 million working Americans. A small base means that relatively minor changes in the covered population caused by market dynamics following implementation of reform proposals will have a leveraged effect on small group insurance average per capita claims.

Figure 2 describes the inter- and intra-market movements that must be considered in estimating the effects of reform proposals on small group insurance claims. There are a number of sound reasons to believe that guaranteed access will increase claims.

Any reform proposal creates the opportunity for uninsurable risks working for small businesses (including self employed individuals) to obtain coverage that is currently unavailable to them.

Removing barriers to entry encourages the dumping of worse risks (whose claims are much higher than average claims) by larger businesses seeking to cut their own claims.

Ineffective planning and policing would leave open the possibility for better risks to move from small group insurance to an unchanged and potentially lower cost (if worse risks are still denied coverage) individual health insurance market, self-insured MEWAs, or to go uninsured.

Unfortunately, none of these market dynamics can be measured with any degree of certainty.

These potentially expensive movements, though, could be at least partially offset by requiring or encouraging large numbers of small businesses to provide health coverage to their employees. This requirement could move many better risks into small group insurance from individual health insurance, coverage as dependents by other employers, and the ranks of the working uninsured. This would at least partially offset the tendency of worse risks to take advantage of opportunities for guaranteed access and better risks to flee to coverages with barriers to entry and, thereby, lower cost.

Actuaries working with the Health Insurance Association of America and the Blue Cross and Blue Shield Association to help develop reform positions have tried to estimate the change in average per capita claims resulting from guaranteed access.¹⁷ However, the uncertainties described above make it impossible to form more than a broad range of possible outcomes. Estimates for small group health insurance with guaranteed access, but without requiring businesses to provide coverage, range from a low of 5% increase to a high of 25% increase in per capita claims. Even with an employer mandate or meaningful incentives for businesses to add healthy people to the small group risk pool, the actuarial consensus is that average claims will increase, but by less than if a mandate or incentives are absent. Incorporating workers covered by individual health insurance into a guaranteed access requirement would significantly cut the potential claims increase by almost doubling the base over which the cost could be spread.

Policy Alternatives.

All reform proposals share the common goal of developing a small business health insurance market that is able to operate much more like, or to become, a social insurance system. Four distinct types of proposals for state or federal legislation are being debated.

- Option 1. Ban some or all of the risk management tools used by insurers to control biased selection in small group health insurance products. No change is made in the underlying market structure.
- Option 2. Ban abusive use of existing risk management tools in small group health insurance products. Develop a public or private sector safety net (reinsurance pool) as a new risk management tool to allow insurers to cover those small businesses with uninsurable risks.
- Option 3. Restructure the private sector small business health insurance market into a social insurance system, free of the need for risk management tools.
- Option 4. Replace the private sector market with a public sector national health insurance program for all Americans.

Judging the advisability and effectiveness of these reform options is helped by exploring their effect on market structure and, consequently, on market behavior. Chart 2 summarizes these characteristics for each of the four options.

Option 1: Ban some or all risk management tools. Some commentators suggest that small group health insurance could be made more available to small businesses by simply banning any, or all of the following: health underwriting, duration and tier rating strategies, pre-existing condition limitations, and insurers' contractual rights to terminate coverage. These suggestions are finding some favor, particularly among state insurance departments that feel a need to respond quickly and directly to consumer complaints.

Banning health underwriting and pre-existing condition limitations removes existing barriers to coverage. Banning duration and tier rating reduces the spread in rates between those small businesses with better risks and those with worse risks. Eliminating or strictly limiting termination rights ends the possibility of unwarranted cancellations. Each of these actions is directly related to consumer complaints and easily understood by regulators, legislators, and the public.

None of these regulatory bans, though, effect market structure. The small business health insurance market is still characterized by an ill defined and unstable population with far less than universal participation, served by a large number of competing insurers, with better business risks constantly seeking low cost alternatives. All four social insurance principles continue to be violated. Biased selection and competition for better risks remain as structural problems faced by insurers participating in the market.

Banning small group health insurance risk management tools without making changes in the underlying market structure encourages a number of dysfunctional market adaptations.

A ban on duration and tier rating strategies encourages churning of insurers in and out of the market by strongly favoring new market participants at the expense of existing participants. New market participants can underprice existing insurers because they have few of the worse risks in their pools.

Regulations aimed at restricting small group business practices favor insurers in other unregulated alternative coverages for small businesses (e.g., individual health insurance and self-insured MEWAs) and encourage better risks to flee to them.

Higher aggregate rates are an inevitable result. Banning duration and tier rating strategies, and thereby increasing cross subsidies among small businesses, raises the rates charged to the significant majority of small businesses with better risks. Banning underwriting and pre-existing condition limitations directly increases aggregate market losses. These increases will exacerbate the uninsured problem by making coverage more expensive and less affordable to marginal small businesses and low income employees.

Regulatory bans of risk management tools will likely encourage insurers and small businesses to find new ways to

compensate for an unchanged market structure. At a minimum, bans will force at least some insurers to stop serving the market or to sell less regulated and less costly individual health insurance. At an extreme, the market may no longer be viable. Faced with pressure to enact these types of laws and regulations, most state insurance regulators argue against them due to these unintended consequences.

While superficially attractive, a policy of simply banning risk management tools will not work without concurrent changes in the market structure to correct for violations of social insurance principles. In this, as in other instances, banning "symptoms" of underlying market conditions without addressing underlying structural problems is rarely, if ever, a sound policy alternative in insurance markets.

Option 2: Ban abusive use of risk management tools and develop a public or private sector safety net (reinsurance pool). This policy option requires private insurers to develop risk management tools to guarantee access to health insurance for all small businesses able to afford coverage. It does not create a social insurance system. The small business health insurance market will continue to violate all four social insurance principles. This approach creates new limits on insurers' businesses practices and new risk management tools (i.e., reinsurance pools) to help insurers operate the small business market in a manner consistent with consumer and political expectations.

Structural and risk characteristics of the existing market create a need for insurers to use risk management tools which, in turn, limit access to coverage for some small businesses and unwind cross subsidies. There are, though, technical changes that can be made to improve the effectiveness of the private market. The National Association of Insurance Commissioners, a number of state insurance departments, insurance industry trade associations, and various insurers have recommended market improvements, including limits on tier and duration rating, banning termination of risks because of poor health, and limiting the use of pre-existing condition limitations.¹⁸ Other ideas, such as improving the ability of private insurers to cover substandard risks and expanding the definition of eligible employees and dependents, are also being tried within the insurance industry.

These changes, if carefully designed and implemented, can increase the availability of health insurance even without making structural changes in the existing market. However, even with these reforms, the existing private market cannot make coverage universally available. There will be individuals who remain uninsurable.

Uninsurables can be guaranteed access to health insurance by creating reinsurance pools. Reinsurance pools are a risk management tool used in some other voluntary insurance markets to allow an equitable spreading of the cost of opening up access to insurance. Some thoughtful public and private administered reinsurance pool designs have been suggested for use in the small business health insurance market. For example, the Health Insurance Association of America (HIAA) recommends a broadly funded private sector reinsurance pool.¹⁹ In their proposal, the HIAA recommends that small businesses pay for a first tier of increased claims. Broader funding is suggested if average claims increase by more than small businesses can afford. Funding excessive claims increases outside the small business market recognizes a societal obligation to keep this market from deteriorating into one with a disproportionate concentration of worse risks.

Banning the abusive use of risk management tools and developing a new safety net for true uninsurables has a number of policy advantages. This option expands the availability of insurance while preserving the wide range of competitive options available in today's marketplace. It also increases public oversight of insurance business practices through new state insurance laws and regulations.

Reinsurance pools are fully consistent with mainstream political solutions to problems with access to other insurances such as workers compensation insurance and private automobile insurance.²⁰ Both of these markets use reinsurance pools to allow access to coverage for worse risks. Some, such as substandard automobile insurance pools in Massachusetts, New Jersey and California, have run into very visible financial problems. However, many other pools are successfully fulfilling their roles.

This option also has its drawbacks. Any reinsurance pool, public or private, is necessarily quite complicated. This makes it difficult to explain to legislators and the public. These reforms may also be viewed by some as inadequate, particularly since a primary proponent is the insurance industry and, increasingly, insurance regulators.

A more fundamental problem is that these proposals lack a means to compel or encourage small businesses not currently providing coverage to enter the market. Guaranteed access to health insurance, by itself, cannot make much of a dent in the number of working uninsureds. The major group of working uninsureds to benefit from these changes are those who are both uninsured and uninsurable. What little research there is suggests that less than 10% of uninsureds are actually uninsurable.²¹ Adding uninsurables in disproportionate numbers to the existing risk pool will, in turn, make health insurance less affordable by increasing average per capita claims, perhaps significantly.

This option does not create structures which solve the fundamental problems of biased selection and price competition among insurers. Violations of all four social insurance principles remain. Appropriately structured risk management tools are used to compensate for these violations. Because this option encourages the addition of mainly worse risks to the small group insurance pool, the cost to small business could be quite high.

Option 3: Create a private sector social insurance system for the small business health insurance market. Proposed changes usually include: requiring businesses to provide health insurance for all employees and their families, restricting competition among insurers, and severely restricting or banning the use of existing risk management tools. The Pepper Commission recommendations is an example of this approach. Although it is not explicitly recognized, this option proposes changes to make the small business health insurance market similar in many respects to the existing workers compensation market.

Using a highly controversial employer mandate to restructure the small business market will clearly reduce the number of working uninsured, but cannot totally be relied upon to create an effective social insurance system. Much of the turnover, superior knowledge, and low participation problems which characterize the market will be solved. However, the Eligibility and Participation Principles will continue to be violated if small businesses are used as vehicles to "dump" worse risks from other markets, and if significant numbers of better risks flee the market for lower cost alternative coverages. These remaining problems could result in a costly increase in biased selection.

Even if the number of competing insurers is reduced, the market will continue to violate the Intermediary Principle. However, developing carefully designed reinsurance pools will effectively compensate for this problem. To be effective, insurers in alternative markets such as individual health insurance and self-insured MEWAs either must be effectively barred from underwriting insurance for small businesses or included in the scope of market reforms.

Continued violation of the Equity Principle also needs to be addressed. Without significant changes in the way losses are financed (e.g., replacing employer paid premiums with less visible taxes), the unwillingness of small businesses to cross subsidize each other remains. This may result in political pressures such as those that followed the enactment of Medicare Catastrophic Health Insurance in 1988 or widespread non-compliance through the use of alternative coverages.

Short of a national health insurance system, restructuring the small business health insurance market into a social insurance system is a difficult, but possible, task. To be effective, the small business market must be effectively isolated from dumping and desertion, and insurers must be allowed to develop effective reinsurance pools. If not carefully structured, implementing this option may create as many problems as it solves.

But, even if effective, this reform package will have its drawbacks. Average per capita claims will increase, but by less than if no attempt is made to cover better risks. In addition, not many part-time employees, and none of the large number of workers with short term episodes of uninsurance will be covered.^{22,23}

Option 4: A national health insurance program. A tax based national health insurance program, with a single public insurer serving the entire population, accomplishes the goal of reforming America's health financing into a true public social insurance system. All four social insurance principles are satisfied.

However, this change is so radical that it is unclear whether Americans would be satisfied with the results. Real concerns exist about the cost of national health insurance, concentration of power in a single bureaucracy, the effect of a bureaucracy on providers, restrictions on the availability of medical care, and the pace of medical innovation. Other Western societies have national health insurance systems. But to date none of these has emerged as a politically viable alternative to America's mixed public and private system.

Choosing an Effective Strategy for Change.

In many important ways, the policy debate about small group health insurance reform has outrun the information available to help design and choose among policy options. Anecdotal evidence and political and social ideology often substitute for a reasoned assessment of the true nature and extent of the underlying problems. The political importance of reform can all too readily outweigh its ability to help solve the real underlying problems.

The small business health insurance market is not, and will be difficult to structure to operate, by itself, as a social insurance system. The large business health insurance market does not provide a workable model for reform. In lieu of a non-existent simple solution, the best model for immediate reform is one that carefully builds upon the existing small business market structure.

An effective model for change would have the following characteristics.

Reforms to Compensate for Violations of the Eligibility and Participation Principles.

To make coverage universally available without unfairly increasing premiums, a public or private safety net is needed. Reinsurance pools, carefully designed to focus on allowing legitimate small businesses which are currently both uninsured and uninsurable to become covered, are the least costly and most effective approach. This minimizes the chances that universal access will destabilize the entire small business health insurance market.

If too many small businesses continue not to offer health insurance, or, if aggregate market biased selection unfairly raises premiums, then it may become necessary to require all businesses to provide their own employees at least basic health insurance benefits.

To reduce aggregate market biased selection caused by dumping and desertion problems, effective policing of eligibility for insurance is needed.

Reforms to Compensate for Violations of the Intermediary and Equity Principles.

To eliminate abuses and maintain equitable cross subsidies among better and worse small business risks, limits to insurers rating strategies and other market practices need to be enacted. The National Association of Insurance Commissioners (NAIC) model law on "Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups" is a well thought out proposal.

To recognize that continued violations of the Eligibility and Participation Principles create significant opportunities for dumping, reinsurance pools must make explicit provision for a safety valve to avoid excessive aggregate market biased selection from unfairly increasing premiums.

To help vulnerable small businesses and low income individuals afford the high cost of fairly priced health insurance, premium subsidies or tax credits are needed.

To avoid unintended opportunities to escape reform, a level playing field is needed among all potential sources of small business health insurance.

To remove impediments which drive up the cost of health insurance, state mandated benefits and laws which prohibit provider contracting activities by insurers should be eliminated.

Encouraging small businesses to join together to negotiate insurance contracts or managed competition plans advocated by Alain Enthoven can also help by potentially reducing marketing costs, some administrative costs, and, if effectively managed, pool losses.²⁴

These recommendations are a combination of proposals from options 2 and 3 described above. They accept the small

business health insurance market structure as it is today: one that violates all four social insurance principles. New risk management tools (i.e., reinsurance pools) and constraints on insurers' business practices are added to allow the market to operate in a manner more consistent with societal expectations. If governments take the major step of requiring businesses to provide health insurance to their employees, then these recommendations move towards a social insurance systems similar to state workers compensation systems.

It will not be easy to design and implement effective programs of small business health insurance reform. There are far too many unpredictable market dynamics and unknown information to determine in advance whether or not a specific reform package will be successful. Perhaps the most effective way to avoid serious mistakes and to encourage needed experimentation is for the states, rather than the federal government, to be focal points for change.

Conclusions

The existing small business health insurance market structure violates all of the social insurance principles which must be met to have a market free of biased selection and competition among insurers for better risks. Insurers, therefore, find it necessary to devise risk management tools in order to build and maintain a viable market. Without these tools it is quite likely that the problems of affordability and availability of small business health insurance would be significantly worse than they are today.

A number of different approaches to reform are being debated. Seemingly straightforward approaches are ineffective and may well exacerbate existing cost and access problems. Other, unfortunately more complicated, options can be effective, but only if carefully designed and implemented. Short of a politically infeasible, and perhaps costly and inefficient national health insurance system, the more complicated options have the greatest chance of success. There are no simple solutions to the complex problems of financing health care.

Perhaps the most glaring weakness of all policy options and almost all proposals presented to date is their failure to adequately address cost containment. In fact, guaranteed access to health insurance for small businesses will increase costs for this vulnerable sector of our economy. Even universal access to insurance and, thus, to health care for all Americans will likely exacerbate the problem of rising costs by adding new demand for health care services. If the real problem, as Daniel Callahan of The Hastings Center suggests, is that we value unlimited medical progress to meet every individual's needs, but at the same time somehow expect it at an affordable price, then the options being discussed are, at best, doomed to marginal effectiveness.²⁵

The American health care financing system is exceedingly complex. Simple solutions to our basic problems do not exist. But, by continuing an open debate, we can begin moving towards the development of a fairer and more efficient health care system for all Americans.

NOTES

1. Tabulations of the March 1988 Current Population Survey prepared for the Pepper Commission by Lewin/ICF, Inc.
2. A Call For Action The Pepper Commission: U.S. Bipartisan Commission on Comprehensive Health Care Final Report (Washington DC: U.S. Government Printing Office, September 1990).
3. Tabulations of the March 1988 Current Population Survey prepared for the Pepper Commission.
4. For example, G. Kramon, "Small Business Is Overwhelmed By Health Costs," The New York Times (October 1, 1989):1; C. Mathiessen, "Uninsurance," Hippocrates (November/December 1989):36; J. Kosterlitz, "Sick About Health," National Journal (February 3, 1990):270; and J.B.Quinn, "The Health Policy Crunch," Newsweek (November 6, 1989):62.
5. The Pepper Commission Final Report:3.
6. For example, testimony of M.V.Nadel and L.Etheredge in "Small Business Health Insurance Market," Hearing Before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce House of Representatives (October 16, 1989); and The Pepper Commission Final Report:27.
7. The Pepper Commission Final Report:59.
8. Bulletin of the Commission on Insurance Terminology of the American Risk and Insurance Association, Vol. 1, No. 2 (May 1965) and Vol. 2, No. 2 (July 1966).
9. F.W.Porell and W.M.Turner, "Biased Selection Under the Senior Health Plan Prior Use Capitation Formula," Inquiry 27(Spring 1990):39.
10. U.S.Congress, Office of Technology Assessment, Medical Testing and Health Insurance, OTA-H-384 (Washington, DC: U.S. Government Printing Office, August 1988):101.
11. An average of figures from, Health Insurance Association of America, The Health Insurance Picture in 1989 (Washington D.C., 1990).
12. Tabulation of data from, Health Insurance Association of America, Employer Survey, 1989 (Washington D.C., 1990).
13. Claim files from the author's insurance company and discussions with other insurers of small businesses. There is a constant, albeit small number of claims which show clear evidence of a wide range of abuses. To the extent that these limited number of claims are skewed towards larger amounts, the cost is disproportionately large. In a market structured to guarantee access to coverage, abuse could become a significant additional cost.
14. Unpublished insurance industry surveys and discussions with insurance company executives.
15. Small Business Employee Benefits, National Federation of Independent Businesses, (December 1985); and Health Care Coverage and Costs in Small and Large Firms, U.S. Small Business Administration (April 1987).
16. Information on actuarial analyses of small group health insurance pricing is drawn from; H.J.Bolnick, "Why Small Groups Fail," Best's Review Life/Health Insurance Edition (October 1983); B.P.Niehus, N.E.Crocker, and G.K.Hawkins, Jr., Financial Management of Small Group Health Insurance, Society of Actuaries Study Note 422-33-89 (1989); and, W.F.Bluhm, "Cumulative Antiselection Theory," Transactions of the Society of Actuaries XXXIV, (Chicago: Society of Actuaries, 1982).
17. Unpublished cost estimates and discussions with actuaries making these estimates.
18. For example, in December, 1990 the National Association of Insurance Commissioners endorsed the "Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups" Model Law. This Model Law is intended to end the abusive use of duration and tier rating

- strategies and unrestrained termination rights. A number of states, including Iowa, Georgia, and Maine have already enacted this Model Law or a variation of it.
19. Health Insurance Association of America, "Proposal on Providing Health Care Financing for All Americans," (1990).
 20. Most states have adopted some form of residual risk mechanism or reinsurance pool to cover unwanted workers compensation and private automobile insurance risks. A thorough review of the form and operation of these various programs may be a helpful addition to the health insurance debate. For a general description of these programs see: C.A.Kulp and J.W.Hall, "Casualty Insurance," (New York, The Ronald Press, 1968).
 21. Cost and Compassion: Recommendations for Avoiding a Crisis in care for the Medically Indigent, (Chicago, American Hospital Association, 1986):102.
 22. Tabulation of the March 1988 Current Population survey prepared for the Pepper Commission.
 23. K.Swartz and T.D.McBride, "Spells Without Health Insurance: Distributions of Durations and Their Link to Point-in-Time Estimates of the Uninsured," Inquiry 27 (Fall 1990):281; and, A.C.Monheit and C.L.Schur, "The Dynamics of Health Insurance Loss: A Tale of Two Cohorts," Inquiry 25 (Fall 1988):315.
 24. A.C.Enthoven, Theory and Practice of Managed Competition in Health Care Financing, (New York: North-Holland, 1988).
 25. D.Callahan, What Kind of Life: The Limits of Medical Progress, (New York: Simon and Schuster, 1990).

Chairman STARK. Thank you. We have saved the best for last. Len Schaeffer, you are on.

STATEMENT OF LEONARD D. SCHAEFFER, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, BLUE CROSS OF CALIFORNIA, WOODLAND HILLS, CA

Mr. SCHAEFFER. Good afternoon. As the chairman knows, I have been an advocate of comprehensive health system reform for many years, but it hasn't happened in the 20 years that I have been waiting for it.

So today, I would like to talk about the things that Blue Cross has done that are incremental in nature, that are affordable, and which have extended health care benefits to more and more of the uninsured.

My comments are based on our experience in California, which is an extremely competitive State, without a single insurer with dominant market share, and where 70 percent of the population is insured by HMO's, PPO's, or managed care products.

Delivery systems, regulatory practices, competition, and demographics vary significantly by region, so any comprehensive national approach has to take that into account.

However, in California, we believe that the private sector can and should develop insurance solutions that can be extended to the majority of those who are currently uninsured. We support a four-faceted approach which is outlined in my written testimony, but I would like to discuss three points today.

First, we believe that the goal of a health care financing organization should be to manage risk, not avoid it. Therefore, we are offering or developing innovative, more affordable products that fill the gaps for specific underserved populations.

Second, we support insurance reforms that improve access to and affordability of insurance, particularly in the small group market.

And third, we advocate a broader set of public policy initiatives to provide coverage to people who private insurance programs can't reach.

I would like to briefly discuss one solution, our small group access program. In the past year, over 80,000 people working for small employers have received coverage with our program, 17,000 of whom probably would have been denied health insurance by carriers using traditional small group approaches.

The small group access program manages the risk in the following ways. First, small group access controls costs by using our contracted network of HMO or PPO providers by implementing appropriate utilization management techniques.

Our costs for a 35-year-old—I just compared this with the Johnson Foundation experiments—is very close to many of those experiments. For an average group, which I would be happy to define later—is about \$110. So, it is in the ball game even though California is a much more expensive State.

Second, the program broadens access, because there are no ineligible industries—no black listing, no limitations based on size or location—no red lining. However, we accept one high-risk group for

every four traditionally accepted groups which brokers and agents bring to us.

Our goal is that 90 to 95 percent of small group applicants will qualify, whereas industrywide estimates are about 60 to 65 percent actually get coverage.

Third, small group access offers affordable and predictable rates to small groups. It uses community rating adjusted only for age in one of six geographic areas in California. High-risk group premiums are 1.3 times traditionally accepted group premiums. The entire pool is re-rated every year as if it were a single group, thus minimizing rate fluctuations for each small group, and renewal premium rates are the same as new business premium rates.

Finally, we offer the same set of benefits to all small groups, both high-risk and traditionally accepted groups. Our total enrollment is about 215,000 Californians, and we are enrolling at a rate of 7,000 to 8,000 new lives a month. It is a very successful program.

However, we also believe that insurance market reforms would be helpful and frankly are necessary if we really want to expand that access. I have provided the committee with a detailed list of our suggestions, which include rate bands, disclosure requirements, benefit mandate exemptions, and repeal of antimanaged care laws.

I would like to focus on three points, though. First, a level playing field—reforms won't work unless all entities offering health insurance play by the same rules. That includes insurers, HMO's, PPO's, MET's, MEWA's, self-insured trusts, on and on and on.

Also—this is a bit controversial—we think all health care financing entities should offer insurance in both the large and the small group market. If you are going to be in the market you are going to be in for groups of all sizes.

Second, portability and continuous coverage—

Chairman STARK. Would you qualify that to say that you would allow then for—arguably, if everybody is in the pool, the risk difference isn't very great, but the administrative costs could be. Would you just say that you should adjust for administrative costs?

Mr. SCHAEFFER. In our plan, the administrative costs are not that dramatically different.

Chairman STARK. In sales costs?

Mr. SCHAEFFER. Yes; sales costs are different.

Chairman STARK. OK, thank you.

Mr. SCHAEFFER. We advocate reforms that would assure continuous coverage as people move between jobs and prohibit waiting periods or waivers for preexisting conditions after the first time group insurance has been obtained. Once you are in the system, insurance should be portable, provided it is continually maintained.

Continuous coverage means that individuals need not seek or change jobs in order to secure benefits to cover an existing medical problem.

We are very concerned about the creation of actuarially credible pools. Our program pools the risk of 16,500 small groups with great success. We don't think it is necessary for government to get into the pooling business. We even question some organizations that exist simply to pool groups and then go to another insurance company. Why do you need three or four levels of administration?

However, there are many people who currently can't be reached by private insurance. Therefore, government intervention is required to, first, create the conditions that ensure a high employment economy; second, directly finance the provision of health care for those unable to find employment; third, provide incentives and require employers to participate in financing health care for employees and at the same time provide incentives or require insurers to make insurance available, so there is some even-handedness there; and finally to address the problem of uninsurables.

In California, Blue Cross administers the California Major Risk Medical Insurance Program, a State-financed fund that pays medical costs beyond actual premiums for individuals denied coverage by private insurers.

I hope this has been helpful. I would be happy to answer any questions.

[The prepared statement follows:]

**Statement of Leonard D. Schaeffer, Chairman and Chief Executive Officer,
Blue Cross of California**

Mr. Chairman and members of the Subcommittee, I am Leonard Schaeffer, Chairman and CEO of Blue Cross of California, the largest health insurance company in California. I appreciate the opportunity to testify today.

Blue Cross of California recognizes its corporate responsibility to aggressively address problems of the uninsured. We need solutions that balance demands for greater access with the need to control increasing health care costs. It is important to find approaches that can be practically implemented now, as they are within our immediate power, within our budget and within the bounds of our political will.

As previous testimony has indicated, delivery systems, regulatory practices, competition, and demographic characteristics vary significantly by region and any successful reforms must take these differences into account.

Blue Cross of California believes that in California, the private sector can and should develop insurance solutions that can be extended to the majority of those who are currently uninsured. Since over half of the uninsured are working people and about twenty-five percent are their dependents, developing affordable insurance products for all employers and their employees and dependents will be key to solving these problems.

Blue Cross of California takes a four-faceted approach:

- First, we believe that the goal of a health care financing organization should be to manage risk, not to avoid it. Therefore, we are offering or developing innovative, more affordable products that "fill the gaps" for specific underserved populations.
- Second, we support insurance reforms that improve access to and affordability of insurance, especially in the small group market.
- Third, we advocate broader public policy initiatives to provide coverage to people who private insurance programs can't reach.
- Finally, we support and sponsor public education campaigns to help address these issues, and to foster individual responsibility for healthy lifestyles and promote the prudent use of health care resources.

THE GAPS IN COVERAGE

Blue Cross of California has identified specific California populations that traditionally lack access to affordable private insurance:

- Nearly two million full-time employees (many in small firms) who don't have insurance due to unpredictable rates, ineligible industry restrictions, or cancellation by a previous insurer including a large fraction of California's sizeable Latino and Black populations;
- The many Californians who find themselves temporarily without health insurance because they leave a job, must wait for insurance to take effect after new employment, or only recently moved to the state;
- The over a half million part-time employees who can't get coverage due to limited work hours;
- Over one and a half million children ages 16 years and under who are without health insurance because the dependent portion of group coverage is too expensive;
- Many seniors who are without long term care insurance, including in-home custodial care coverage;

- The uninsured who cannot afford traditional comprehensive health insurance, or who can afford only limited coverage;
- A quarter of a million Californian's who are medically "uninsurable."

Similarly, many people, though Insured, have Inadequate coverage. Among these groups are:

- Many California women whose Insurance plans lack maternity and pre-natal coverage;
- Individuals whose policies don't cover pre-existing conditions;
- Californian's who lack affordable mental health coverage.

FILLING THE GAPS

We have worked aggressively to develop affordable new products that target these groups. Blue Cross of California's solutions include:

- Small Group Access Program

Our very successful Small Group Access program is aimed at providing insurance opportunities for small employers, a group neglected or avoided by many insurers.

- In the past year, over 80,000 people working for small employers have received coverage, 17,000 of whom would probably have been denied health insurance by carriers using traditional small group approaches.
- Small Group Access *manages* the risk by controlling costs, increasing access, and offering more affordable and predictable rates for a complete Blue Cross benefit plan.
- First, Small Group Access controls costs by:
 - using our contracted network of PPO providers;
 - implementing appropriate utilization management techniques.
- Second, this program broadens access because:
 - there are no ineligible industries (no "blacklisting");
 - no limitations based on size or location (no "red lining");
 - we accept one high risk group for every four traditionally-accepted groups which brokers and agents bring to us;
 - our goal is that 90-95% of small group applicants will qualify; industry-wide, estimates show only about 60-65% of applicants are accepted.
- Third, Small Group Access offers *affordable and predictable* rates to small groups:
 - it uses community rating adjusted only for age and one of six geographic areas. Rates are published annually;
 - high risk group premiums are 1.3 times traditionally-accepted group premiums;
 - this large pool is re-rated every year as if it were a single group, thus minimizing rate fluctuations for each small group;
 - renewal premium rates are the same as new business premium rates.
- Finally, Blue Cross offers the same set of benefits to all small groups, both high risks and traditionally-accepted groups.
- Our total small group enrollment is now over 200,000 Californians.

- We sell only Small Group Access plans and are enrolling 7,000-8,000 new members per month.
- Thus, BCC is offering a competitive, affordable program that directly assists workers in small firms. We urge other Insurers and HMOs to take similar steps in the small group market.
- Temporary Medical Program

Besides competitively priced Individual policies, Blue Cross of California will soon offer a program specifically addressed to short-term spells where Individuals lack insurance while between jobs. This is an affordable, managed care major medical plan that becomes effective immediately and covers any accidents or medical conditions that subsequently develop.

- Part-Time Employees Program

In 1992, Blue Cross of California plans to extend its Small Group Access Program to employees who work as few as 17.5 hour per week. (Other Insurers only cover employees who work as few as 30 hours.)

- Children/Non-Traditional Family Coverage

Blue Cross of California offers special discounted rates for children as well as single parents on our managed care Individual policies. By the end of this year we will expand this program to cover early prenatal care and childhood immunizations with the policy deductible waived for these services.

- Complete Senior Coverage

Last year Blue Cross of California pioneered the first Medicare supplemental policy that includes custodial care and a whole range of other services — UltraCare Plus. Under this plan, a professional care coordinator visits policyholders in their homes to help plan and arrange appropriate chronic care including day care, social services, chore and meal assistance, In-home care, transportation, and "time-off" for spouses or caregivers. The plan continues coverage if policyholders eventually require nursing home care.

- Catastrophic Hospital Coverage

Blue Cross of California offers several low-cost plans that cover hospitalization-related expenses only, to those who desire a "safety net" for catastrophic expenses. These products are very affordable, with an average monthly premium of \$20-\$50 per person for \$2 million worth of coverage.

- Behavioral Health Access

Blue Cross of California has developed a more affordable, contracted managed care mental health network. This plan, currently available to large groups, will soon be introduced to the small group market. This program allows expanded benefits and reduced co-payments due to Blue Cross of California's ability to negotiate unique managed care discounts with providers.

- Minority Outreach Program

Our Minority Outreach Program meets the needs of California's diverse ethnic population. Minority agent recruitment, agent co-op advertising and foreign language product and health education literature are distributed to California's multicultural population.

In addition, Blue Cross employs translators fluent in sixteen languages in our customer service units.

INSURANCE REFORMS

Blue Cross of California believes that legislation correcting abuses in the small group market will expand affordable options for small employers, and meet the objectives of access to and fair pricing of health coverage. Blue Cross of California supports the following California reforms:

1. Establishing a "Level Playing Field"

- Reforms won't work unless all entities offering health insurance play by the same rules, including insurers, HMOs, PPOs, METs, MEWAs and self-insured plans.
- All these health care financing entities should register with and be regulated in a consistent manner by the state.
- All health care financing entities must offer insurance to both large and small groups.
- It's interesting to note that, in California at least, some of the strongest advocates for small group reform don't offer coverage to small employers.

2. Portability/Continuous Coverage

- We advocate reforms that would assure continuous coverage as people move between jobs and prohibit waiting periods or waivers for pre-existing conditions after the first time group insurance has been obtained. (Once you are in the system, insurance should be portable providing it is continually maintained.)
- Continuous coverage means that individuals need not seek or change jobs in order to secure benefits to cover an existing medical problem. Such activity is analogous to trying to buy homeowners insurance while your house is burning down.
- This can be accomplished by enacting a state "COBRA-like" benefit continuation law for groups under 20 lives.
- For the first three months of employment, employers would reimburse new employees for their COBRA extension or individual insurance.
- After three months, the employer must cover the employee under its existing plan.
- Thus, there would be no pre-existing condition exclusions, waivers or waiting periods provided coverage has been continuous (i.e., continuous employment or COBRA or individual insurance).
- If enacted, all California health financing organizations would then be required to guarantee issue and guarantee renewal down to the minimum group size for COBRA extension.

3. Rating Limitations:

All entities should comply with the NAIC standards for rating and renewal practices for small groups. We recommend that rate bands for small groups should be limited to +/- 30% with adjustments only for benefit plan, age of insureds, family size and geographical region. Other factors (including industry and class of business) would be included within the +/- 30% band. Renewal

rates would be allowed at a maximum annual increase of no more than trend plus 15%.

4. Disclosure Requirements:

All entities must provide written disclosure to small employers of the rating practices used by the carrier.

5. Exemption from Benefit Mandate Laws:

Coverage offered to small employers and individuals would be exempt from state laws that mandate certain benefits, require that certain benefits be offered and mandate that certain types of providers be reimbursed.

6. Repeal of "Anti-Managed Care Laws":

Laws that prevent or inhibit health care financing entities from selective contracting with providers or prevent or inhibit any managed care activities should be repealed.

7. Creation of Actuarially Credible Pools

Our Small Group Access Program pools the risk of 16,500 small groups with great success. The government should support the private sector as the best vehicle to create community rated pools by enacting appropriate small group reforms. When health care financing organizations perform this pooling function, there is no need for government-run pooling mechanisms.

PUBLIC POLICY INITIATIVES

There are many people who currently cannot be reached by private insurance. Therefore, government intervention is required to:

- first, create the conditions that insure a high-employment economy, so that most individuals will have access to health insurance through their employment.
- second, directly finance the provision of health care for those unable to find employment, by virtue of age, disability, and/or lack of marketable skills.
- third, provide incentives or require employers to participate in financing health care for employees, *and at the same time* provide incentives or require insurers to make insurance available.
- finally, address the problem of "uninsurables" - people whose existing medical problems require a public financing, not an insurance, solution.

Blue Cross has joined the state of California to address the problems of the "uninsurables" through the California Major Risk Medical Insurance Program (MRMIP). MRMIP is a state-financed fund that pays medical costs beyond actual premiums for individuals denied coverage from standard plans. Blue Cross administers the plan and participates along with other carriers. Over 5,000 people are currently enrolled.

PUBLIC EDUCATION CAMPAIGN

Blue Cross of California believes that the public must be informed and involved if we are to find permanent solutions to these problems. In addition, consumers must learn to take individual responsibility for adopting healthy lifestyles and to make prudent choices in the use of health care resources. Blue Cross activities in support of these goals include:

- Health Policy Symposia focusing on health policy issues. Last year's symposium addressed international health care system comparisons; this year, we will examine how different states approach problems in health care delivery and finance;
- Blue Cross of California Foundation for Health Care Effectiveness supporting community activities that promote health care education, prevention and wellness including pre-natal and child health care programs;
- Consumer Health Advocate program, promoting individual responsibility for making healthier lifestyle choices and for using health care resources wisely. The program offers speakers to the community on current problems in health care financing and delivery, and produces a quarterly newsletter distributed to more than 200,000 members as well as Blue Cross employees.
- Senior Alliance, serving the over 65 population with a quarterly newsletter distributed to more than 220,000 seniors, a statewide speakers program, and an information and referral system that assists seniors and their families find services in their communities.

These types of public education efforts must be supported by the government and the private sector in order to reach all Americans and stimulate meaningful changes in behavior.

CONCLUSION

Changes in health care financing and delivery are necessary - and inevitable - if we want to find solutions to the problems we face as a state and as a nation. Blue Cross of California believes the private sector, in conjunction with the government, should take an active role in providing these solutions.

Blue Cross of California will continue to work to "Fill The Gaps" in our current health care system by crafting products to meet specific needs, supporting public education and working toward legislative solutions that improve affordability, access and availability of health benefits.

Chairman STARK. Thank you. Mr. Bolnick, you sell a lot of insurance to small groups only?

Mr. BOLNICK. That is true, sir.

Chairman STARK. Can you give me a premium range? I know that is tough, but if you take what I would call Blue Cross low option, or somebody else had a plan here that they were selling for \$200, \$195 a month. What is your core, low-option plan, and what does it run?

Mr. BOLNICK. Well, this is kind of a rough, gross number just like Mr. Polk gave you?

Chairman STARK. Yes; that is fine.

Mr. BOLNICK. It is the same range. It is \$200. Now, that is a kind of conglomeration of all the age, sex, plan, area factors that go into the rating, but our average person, if I were to pull one out of the pool and say what are you paying, he would pay \$200.

Chairman STARK. That's \$2,400 a year.

Mr. BOLNICK. Right.

Chairman STARK. And your plan is \$110, about, for an individual, half of which the State is picking up. So basically, you have to compete in New York against a subsidized plan where the employer is only having to come up with \$50 or \$55?

Mr. BOLNICK. That \$200 on average would be for two people.

Chairman STARK. So you are at \$100—

Mr. BOLNICK. A hundred dollars per person would be much more comparable to that.

Chairman STARK. Now that sounds very low.

Ms. WINTRINGHAM. I should just clarify. The subsidized program is just the special demonstration.

Chairman STARK. OK.

Ms. WINTRINGHAM. For our regular small business program, there is no subsidy.

Chairman STARK. OK. What would happen to each of you if I waved my wand, if anybody would pay any attention, and we said OK, there may be no medical underwriting and open enrollment and community rating are required. And let us say that for a period of 5 or 10 years you would have to protect your two Blue plans, which have already been saddled with arguably a lot of the higher risk folks so that your competitors would come into the market absent their picking up their average share of high risk. And I guess I would even anticipate that we would have some kind of a global risk limiting, a reinsurance program.

But if everybody is in that program, don't we really have a de facto, nationwide risk pool, once you balance out those people who have been in it longer? I mean, isn't that a risk pool by definition?

Mr. SCHAEFFER. I think if everybody is on the same playing field, we are for that.

Chairman STARK. But I am just asking the one question. I am not trying to commit you. I am just saying, if every insurer—self, group, profit, nonprofit—in the country was prohibited from medically underwriting and had to have open enrollment and community rating, just the nonmedical underwriting and open enrollment, doesn't that virtually say that the industry in totality is the risk pool?

Mr. BOLNICK. No.

Chairman STARK. No? Why do you say no?

Mr. BOLNICK. What you are doing is because that is a broad statement, it covers a lot of different markets which I would have to assume you weren't going to wave your magic wand over.

In other words, employer based insurance—would it go away in this and everybody was in one risk pool where the rules were all the same and each person was—

Chairman STARK. They would have to abide by the same rules to the extent that the large employer couldn't dump some employees. I mean, if it was going to insure one employee, it would have to take them all. It couldn't take some employees and put them in Blue Cross and keep the others in their self-insured plan.

Technically, or as kind of an economic question, I would assume that that by itself creates a national risk pool.

Mr. SCHAEFFER. Well, each organization that has a pool of risk has a different risk pool.

Chairman STARK. Yes, but I am talking about risk pool in the sense of the high risk—

Mr. SCHAEFFER. They would all go somewhere, I think is what you are getting to, provided the cost was low enough for them to find a home and provided that the employers wanted to get the insurance.

I mean, we have heard today that many employers don't insure their employees because the costs are too high. One of the questions that I think you want to ask from a public policy point of view is, what does too high mean? Does it mean that the company goes bankrupt, or does it mean the profits are lower?

Chairman STARK. I guess my question is that—

Mr. BOLNICK. Mr. Stark, can I take another stab at it a different way?

Chairman STARK. I beg your pardon?

Mr. BOLNICK. I follow what you are saying, and I think it is an important—

Chairman STARK. Let me go back a bit. We have talked in the past about risk pools for uninsurables, I mean, for diabetics and people with high blood pressure who are generally denied health insurance. And then we said, why don't we put them into something—there are State risk pools around now. I think 19 States have them.

I am not talking about the uninsured people at all. They are not in anything. I am just saying that then there would be in fact no need to have separate risk pools. The insurance industry in its totality would be the risk pool. A small company, a very small company might reinsure, as I suspect they may now. But without medical underwriting, everybody is in the pool.

Ms. WINTRINGHAM. Under the rules that you are proposing, what we would basically do then is compete based on our own internal efficiencies.

Chairman STARK. Yes, or on managed care or on—

Ms. WINTRINGHAM. That is right, and on benefits and on the way we market the program.

Chairman STARK. Precisely.

Ms. WINTRINGHAM. And frankly, under that set of rules, I am more than willing to take that risk.

Chairman STARK. I am not even asking. I am trying to find out if I am correct in the assumption that that is basically what happens.

Mr. VAN VALKENBURGH. To some extent, that is true, or it would be true, particularly when you started. However, unless part of your wand includes each company marketing in exactly the same way, you would very quickly find that some companies didn't answer the phone quite as quickly as other companies to find out who was calling—

Chairman STARK. Like my friends in Maryland, MD-IPA, when I tried to call and find out about the doctor, yes.

Mr. VAN VALKENBURGH. Yes, so that fairly quickly, while it is true that everyone would have access to a risk pool, but fairly quickly the nature of those pools would change somewhat. Some would be worse because the companies say, we will actively recruit people. Others would be—

Chairman STARK. What you are really saying is you guys are very good at what you do, and that is identifying risks.

Mr. VAN VALKENBURGH. We do have more people enrolled in our small group pool, if you will, than are enrolled in all of the State high-risk pools across the country, and yet we take everybody who applies.

Mr. SCHAEFFER. Mr. Chairman, I think the point I just wanted to mentioned was that guaranteed issue all by itself wouldn't put everybody into a pool, because there are some employers who choose not to go.

Chairman STARK. Absolutely, I see that.

Mr. SCHAEFFER. They might be good risks. They might be very healthy people, they just don't want to get—

Chairman STARK. My own feeling, and maybe you all would like to comment on this—the best rate I can think of is Medicare, which we think might cost \$1,000 a year for every under-65 individual. We can give you Medicare benefits with a \$2,500 out-of-pocket cap and first-dollar care for pregnancy and children.

If you packaged that together, our estimate is that we could offer into the market at no cost to the Federal Government those Medicare benefits—with \$500 deductible and the copays—for \$1,000.

Now some of you seem to suggest that you get close to that, I suspect with some medical underwriting, which we don't use. But nonetheless, even with that, I think the evidence shows that there are just a lot of employers and employees who are not going to pony up \$100 a month voluntarily, regardless of the combination.

Where, as a practical matter, that is only 50 cents an hour in a 2,000-hour work year. So our National Association of Independent Businesses is pretty chintzy in my book. I mean, 50 cents an hour isn't going to break anybody, particularly if everybody in the country has to pay it at once.

But you would think that they would rather have Yeltsin come in and take over the Department of Commerce than they would pay the 50 cents an hour to insure people.

Having said that, don't we then just have to mandate coverage? You all sell insurance, a lot of it. Is there a way, at this price—at \$1,000—if you agree with me that we are still going to have a lot of people, part-time employees—what do you do? A person works, a single mother, at one-and-a-half times poverty, works 15 hours a

weekend as a cocktail waitress, works 20 hours a week at Nordstrom, and ends up with no health insurance. She basically works and gets some public assistance.

Now, the only way it seems to me we are going to get that person and those dependent kids into the bucket is to mandate it somehow. Do you have another idea? I mean, you can't sell to those people. They won't buy your product, will they?

Mr. BOLNICK. The Robert Wood Johnson people said the same thing, and everybody I have heard from or seen done says you just can't sell those people at a fairly allocated cost of health care in this country.

Whether the mandate is the way to go, I mean, as an insurer—
Chairman STARK. I don't like that word—

Mr. BOLNICK. Neither do a lot of people—

Chairman STARK [continuing]. And neither does the Chamber of Commerce. That is a bad word this year. It is like tax—don't say it.

Mr. BOLNICK. As an insurer, I am sure you are surprised that we are not jumping up and saying, gee, that doubles our market. We are all for it. And I think that some sort of statement—

Chairman STARK. Where it doubles your market? Do you sell supplemental?

Mr. BOLNICK. We are going to, believe it or not, be getting into the marketplace—

Chairman STARK. Isn't that a more profitable market?

Mr. BOLNICK. Medicare supplement?

Chairman STARK. Particularly if you had a catastrophic limit. You have no long tail. Even I think I could figure out a profitable policy on that. I mean, that is what I am offering to you guys through Mediplan is 180 million prospects for supplemental insurance with far less risk.

Some of you may care to comment. I like what all of you are doing, and I think it is going to make the overall market more efficient, but unfortunately, I still think we are going to end up with 20 million people that are falling through. Despite each of you and your best efforts, we are still going to have 20 million people at any point in time outside the system.

Would you all agree that if I can get them in the system, it saves you and your customers money?

Mr. VAN VALKENBURGH. Well, if everybody is in the system, there are a couple of things. In a sense, the risk pool is better. There is no presumption, certainly on our part, that the people who aren't insured are worse risks than the people who are insured overall, I mean if everybody is in.

It certainly prevents a certain amount of cost shifting. It comes up again to the dollar numbers, and if you have a solution for that, I know a lot of people who would be delight to hear it—

Chairman STARK. Do any of you see a cost solution other than all-payer or single-payer?

Mr. SCHAEFFER. Yes.

Chairman STARK. What?

Mr. SCHAEFFER. If everybody is in, total costs will go up. Costs to our customers might go up at a lower rate, but clearly if everyone has health insurance—and I think they should—what you will see is higher utilization, so the total cost will go up.

Chairman STARK. What I am suggesting is, is there any way to control that cost that you can think of other than—and I am talking about for the country—than either a single-payer or all-payer system?

Mr. SCHAEFFER. Well, some of the techniques that were mentioned by the folks from Robert Wood Johnson have been successful in other environments. HIP is an HMO and a very effective one. We have a HMO and a PPO. We think it controls costs. I think those mechanisms will slow the rate of increase.

Chairman STARK. But they will still allow shifting. I mean, that is the problem always, that it will control costs for your customers or for your customers—

Mr. SCHAEFFER. Right.

Chairman STARK [continuing]. But not Mr. Bolnick's customer. I guess what I am saying is—I keep getting forced into this. This is not something that I dreamed up, certainly. I don't know which medical economist did, but unless we have on the payment side either an all-payer or a single-payer system—you kind of have all-payer in New York, right?

Mr. VAN VALKENBURGH. All-payer but.

Chairman STARK. All but Medicare.

Mr. VAN VALKENBURGH. Only for hospitals.

Chairman STARK. Only for hospitals.

Ms. WINTRINGHAM. That is right.

Chairman STARK. Yes. It is not considered socialism. [Laughter.]

Mr. BOLNICK. Mr. Chairman, I just, after a few year's absence, joined a new hospital board in the Chicagoland area, and I recalled having been on the board a few years ago and looking at the contractual adjustments and seeing them being about a third of the gross charges, and that was consistent with some studies about how much cost shifting was going on at that point in time.

I was absolutely amazed to get back on a board and find that the contractual adjustments were now 50 percent of gross revenues, which is certainly supportive of what you are saying that—

Chairman STARK. Can you see the poor guy who walks in without insurance who says, I can afford this hospital, and they say wow. I bet they would wire all through a thousand bed hospital if they keep that guy for a year.

Mr. BOLNICK. They love commercial insurance coming in.

Chairman STARK. Thank you all for your testimony. I look forward to continuing to work with you as we wind through this fascinating topic. [Laughter.]

Next we will hear from the National Association of Insurance Commissioners, represented by Mr. David J. Lyons, the commissioner of insurance from the State of Iowa.

STATEMENT OF DAVID J. LYONS, COMMISSIONER OF INSURANCE, STATE OF IOWA, ON BEHALF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Chairman STARK. You are replacing Mr. Pomeroy, who I guess you kicked out for saying that he would go for national regulation if we didn't get it in 2 years?

Mr. LYONS. No comment on that, Mr. Chairman.

Chairman STARK. So much for him.

Mr. LYONS. I don't know. I think he was involved with the Honorable Mr. Dingell yesterday, so I am not sure. Maybe the wounds are too deep.

I want you to know that I am a panel of one, but that is not by accident. I had the insurers in front of me and the self-insurers behind me. I wanted to avoid guilt by association.

Chairman STARK. You want to be right in the middle, fine. We could put you on both panels if you like.

Mr. LYONS. No; I am comfortable being between them.

Chairman STARK. OK.

Mr. LYONS. You have heard a lot of testimony already today about the tragic fact that we have 33 million uninsured Americans and, therefore, without insurance, have no meaningful access to health care in this country.

Specifically, we are discussing the issue of whether the private insurance market as we know it today can be modified or can be reformed to do three basic things: First, eliminate abuses that have been cited all day; second, meaningfully increase access to health care insurance and, therefore, health care for a significant portion of these 33 million; and third, to do those two items within a structure that can hopefully be affordable to a broader spectrum of society than it is presently affordable to today.

The discussion so far has centered on the effects on small business 2 to 25, and I think rightfully so. This group represents the focal point for about 60 percent of the uninsured Americans, and it also represents the area of insurance most pressured by abusive practices and least able to defend itself.

Small business has made the point clear to State legislatures and insurance regulators on the State level just the same as has been happening with Congress. They need solutions, and they are not shy about telling us what the problems are.

The first problem is they don't have the information up front regarding how their rates are set and how they can change in the future. Basically, "I didn't know what I was buying, I didn't know how to get out of it, and I didn't understand what happened to me when I got renewed."

The answer is that we should require increased disclosure to consumers on all insurer rating methodologies that will be used—present and future—prior to the policy ever being delivered.

Chairman STARK. Try this at your next Iowa corn roast. I do it all the time, and I have done it with as sophisticated a group as insurance executives and/or benefits managers. Ask them, if you have a roomful of 20, to take a test. With insurance executives, you would figure they would hit 90 percent.

Ask them to take a test on their own health insurance plan benefits, and see how many can come within the 90 percentile of accuracy. First of all, they will all know about what it costs a month—their side. They may not know what the company is paying. For sure, they will flunk that one, unless they are the treasurer.

Second, they will be pretty quick to say 80 percent of hospital charges are covered, and they may forget whether they have to get a second opinion on surgery or not, but they will flunk number of days of mental health benefits and the age at which the kids go off.

Most of us don't know—we really don't. I mean, we know we have it, vaguely. It is like we don't know what is in our homeowners "C" policy.

Mr. LYONS. And there are three faults there. The first is on the insurer's part, and the second is on the employer's part. And the third part is the individual doesn't—

Chairman STARK. People tend to say, I am insured. And that to them, if they are not sick or haven't had a family member ill, that is their comfort level. I have health insurance.

Mr. LYONS. Second, there is too much volatility in durational, which is the time-oriented rating practices, and tiered, which is the experience-oriented rating practices—there is too much volatility in those rates for small employers for them to be able to stay in the market for any significant length of time.

The answer to that is pretty simple too. Strong limitations have to be placed on rate disparity among groups, and limits should be developed to cap any type of annual increase at some kind of an acceptable level which recognizes risk but does not represent catastrophic increases.

The third problem, and most often brought out, is that small business doesn't believe its State regulators have enough information to adequately regulate the rates when they are set on the State level.

That is probably correct. But also contained within that answer is the requirement of independent actuarial certification of all rating methods used for small business underwriting in your State.

The fourth item is that small businesses feel they have insurance needs which no one will respond to. The answer is pretty simple, and that is simply to guarantee small business availability of health insurance in your State.

The fifth item they have is that small business feels they have no control over the decisions by insurers to refuse them or to choose not to renew them.

The answer is to put the strictest possible limitations on any—any termination whatsoever, and also to put very strict limitations on the fact that if you are going to allow insurer to participate in the market, you must allow and require that they be guaranteed renewable—that there must be somewhere that person can go the second, third, fourth, fifth, sixth year. Guaranteed availability and strict limitations on renewals.

The sixth problem is that interruptions to coverage can be disastrous, both for the employer and for their employees, and that includes many of the issues you have heard today.

The answers again are fairly simple. You prohibit new waiting periods. You prohibit preexisting exclusion periods, and you guarantee the portability of coverage if the employer chooses to move from plan to plan, or the employee chooses to move from employer to employer.

It may sound like I am being overly simplistic—

Chairman STARK. How do you include in that the multiple employer-employee?

Mr. LYONS. What I was going to say is all of these answers you have heard to these questions are exactly what we have done in the two models of the NAIC. One was adopted in December. The

legislature started meeting in January. Six States have it already. I guarantee you another six will have it—you are going to have this doubling factor, because the States are responding to this issue because they have no choice. I mean, the public outcry is there.

So if those are the problems, that goes a long way toward trying to solve them. It gets us down the road. And one point I would make relating to community rating, if these do not move far enough fast enough for public policymakers, they still, at the same time, set all the underpinnings for a transition to community rating in the future.

The last two issues that small business make known to us every day, first of all, I can't afford health care even though it might be available to me. Our answer and our model bills do not reflect any kind of a magic answer for that. It does not do anything other than say this is still a zero-sum game.

The dollars going into the system may be shifted around. The bottom 90 percent may be increased a little, but the costs for the top 10 percent are decreased a lot to keep them in the market. But I think there is plenty of room for a State and Federal partnership on financing of the health care system for the individuals who purely on price cannot participate.

The second issue they raise is that the good risks keep fleeing to ERISA and self-insurance, and they can't afford that. I think that if your goal is to expand risk over the largest group possible, I think it is unfair to expect substantial success unless you have given it the entire field.

And that would mean that I think there is room for Congress to reconsider ERISA, although I would note that multiple-employer trusts and multiple-employer welfare arrangements are now coming under more scrutiny in the States, and the States are applying more of their requirements. So as we pass these model acts, we will be bringing in MET's and MEWA's, because the Federal Department of Labor has made it known to us that we do have that jurisdiction now.

[The prepared statement follows:]

**Statement of the National Association of Insurance Commissioners, David J. Lyons,
Commissioner of Insurance, State of Iowa**

Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to discuss the important topic of reforming private health insurance.

I am David J. Lyons and I am the Insurance Commissioner for the State of Iowa. I am here today representing the National Association of Insurance Commissioners ("NAIC"), which is a nonprofit association whose members are the insurance officials of each state, the District of Columbia, and four U.S. Territories.

One of the most important public policy issues facing state and federal officials is the tragic fact that over 33 million men, women and children have no health insurance and therefore have severely limited access to health care itself. The core problem underlying this tragedy is the seemingly intractable issue of soaring health care costs. The resolution of this problem will involve a substantial, coordinated effort among federal, state and local officials, health care providers, employers, individual consumers, labor, and public and private insurers.

Unfortunately, the rating and underwriting practices in the health insurance marketplace increasingly are contributing to the access problems of many Americans. These problems have caused state regulators, and others, to look more closely at the practices of health insurers and their effect on consumers. My testimony will describe recent activities of the NAIC both to improve the fairness of health insurance rating in the small group market and to increase access to insurance for small businesses.

ROLE OF STATE REGULATORS:

Generally, state insurance regulators are charged with assuring that insurers have the financial resources to meet their commitments to policyholders, reviewing the appropriateness and consistency of underwriting standards and the premium rates, and providing for the fair and efficient operation of the marketplace. Regulators must allow for a balance in the marketplace -- insurers should have sufficient flexibility in terms of rates and market practices to encourage them to make coverage available, but should not be allowed to charge excessive rates or treat policyholders unfairly.

The NAIC assists the states by developing model laws and regulations in areas of common regulatory concern. These models are prepared by regulators from various state departments within the NAIC's committee structure. The Accident and Health Committee has primary responsibility for developing model standards regarding health insurance rating practices. All models developed by the Committee are presented to a plenary of all of the state Insurance Commissioners for final approval.

Model Legislation

The health insurance market is very competitive. Because individuals and groups have both a choice of insurers as well as a choice of whether or not to insure, the health insurance marketplace by necessity operates differently than public health programs such as Medicare and Medicaid. Insurers have developed techniques to assess the potential claims expenses associated with individuals and groups and to charge rates that will fund those expenses.

Recently, state insurance regulators have received growing numbers of complaints from small employers about practices in the health insurance market. Large rate increases and refusals to renew coverage are frequently cited problems. Further, the total inability of some small businesses to get coverage because of the health problems of their workers is an area of growing concern.

The NAIC is addressing both of these problems through model legislation. Last December the NAIC adopted a model law to address rating abuses and renewability problems in the small group market. We currently are developing model legislation aimed at assuring availability of coverage for small businesses, regardless of their employees' health status or claims experience. We expect adoption of this model later this year.

Rating And Renewability Model Act

Premiums for small group health insurance are for the most part determined through competition. In recent years, insurers have begun competing for business by offering low rates in early years and "building in" rate increases if the group continues with the insurer. This is called "durational rating". Low initial rates are possible because insurers medically underwrite (use health screening) to assure that the group is healthy before they accept it for coverage. A healthy group will generally produce lower than average claims experience, so the insurer can charge lower rates initially. However, the benefit of health underwriting "wears off" after two or three years (some employees will become sick or have accidents), requiring the insurer to raise rates to fund the predictable increase in claims.

Insurers also are increasingly using claims experience and/or health status to determine rates in this market. Because initial rates are low, insurers, on average, need to raise rates for groups that continue with the insurer. However, if the insurer builds-in rate increases for all groups, the healthier groups (who can pass medical underwriting with another insurer) will move to another insurer to keep a low initial rate. In response, insurers have developed "tier rating". In tier rating, the claims experience of a group is used to select its premium level at renewal. Insurers increase rates more for groups with poor claims experience (e.g., high claims frequency, employees with serious or expensive illnesses). In some cases these rate increases have been extremely high.

In many cases, insurers also can choose not to renew coverage for a group. For example, an insurer may choose not to renew a group's coverage because the group has poor claims experience or because an employee or dependent has developed a serious medical problem or disability. Groups that are not renewed for these reasons will have a hard time finding replacement coverage because they will be unable to meet insurer medical underwriting standards.

As increasing health care costs gradually erode the affordability of coverage for small businesses, the problems inherent with these rating practices become exacerbated. Price competition to produce the lowest rate for new business appears to be causing more aggressive use of these rating practices. Groups with higher claims experience are more and more experiencing large premium increases or, sometimes, nonrenewal of coverage. In some cases, these groups can and do reduce their costs by dropping a sick employee from the group, leaving that employee uninsured and sometimes uninsurable. The market's focus has shifted away from long-term sharing of risk across a relatively large number of groups and towards providing a low, short-term price to select groups.

In response to these problems, the NAIC in December of 1990 adopted model legislation aimed at rating and renewal practices in this marketplace. The Model: (1) places limits on certain rating practices and requires actuarial certification of rating methods; (2) limits significantly an insurer's ability not to renew a group's coverage; and (3) requires increased disclosure to consumers of insurer rating methods.

The rating limitations in the NAIC Model provide that: (1) within any class¹ of small group business, rates for similar groups for similar coverage can vary by no more than 25% around the midpoint; (2) for all classes of business, the midpoint rate of any class may not be more than 20% higher than the lowest-rated class of business; and (3) in any year, the maximum increase that an employer may receive would be equal to the change in the rate for new business in that class plus 15%. A change in the number or make-up of employees also could affect the employer's rate at renewal.

Essentially, in any year, the maximum change in rate that could be attributable to a group's health status, claims experience or duration of coverage is 15%. Otherwise, the annual rate change is based primarily on the change in rate for new business -- which should reflect the trend in health care costs and utilization. The new business rate was chosen as an index because insurers are heavily penalized if they cheat: if they raise it too much they would be uncompetitive for new business; if they keep it too low, they would be underpricing the entire class and incur significant losses.

The overall rate bands described above are designed to assure that rates will not vary excessively within a class of business or within the insurer's entire book of small group business. The NAIC Model permits some variation in the rates of an insurer (if based on actuarially sound rating principles), but its enactment would significantly compress the degree of rate variation that currently exists.

The NAIC Model also requires each insurer to keep on file for examination a detailed description (including documentation) of the insurer's rating methodology and underwriting practices. In addition, each insurer must file an annual actuarial certification that the insurer's rating methods are based on sound actuarial principles. These requirements will improve the ability of insurance regulators to monitor the rating practices of insurers and enforce the limits on rating practices described above.

In addition to the rating provisions, the NAIC Model significantly limits the ability of insurers to nonrenew coverage. The NAIC Model: (1) generally prohibits nonrenewal by the insurer of individuals or dependents within a group; (2) generally prohibits the nonrenewal by the insurer of groups within a class of business; and (3) permits nonrenewal of a class of business only upon notice to the groups and to the commissioner.² An insurer that does not renew a class is prohibited from starting business for a new class for a period of five years.

These renewal provisions go a long way toward guaranteeing continuity of coverage for small businesses and their employees. Nonrenewal of specific groups or individuals is generally prohibited. Further, the penalty for nonrenewal of an entire class (i.e., prohibition against writing new classes of business for five years) should discourage nonrenewal except in the most

¹ Insurers use separate "classes" or "blocks" of business to distinguish different groups of business that should produce different results. The factors being contemplated by the task force for defining "class" include business that is insured through or for a bona fide association, business marketed through a different method of distribution (e.g., agent sold or direct marketed), and a class acquired from another carrier.

² Nonrenewal also would be permitted in cases of fraud, failure to abide by provisions of the contract, or if the small employer is no longer engaged in business.

extreme cases where the insurer is unable to continue to provide coverage or is leaving this market altogether.

Finally, the NAIC Model requires insurers to disclose the following information at the time of purchase: the insurer's right to change rates; any factors, including the group's claims experience, health status, or duration of coverage, that could affect the group's rate; the class of business the group would be placed into; and the conditions that affect renewability of coverage. Disclosure of these factors will enable small businesses to make more informed purchases of group coverage and to better understand how their rates may change at renewal.

Together, we believe that these rating and renewability provisions will improve the stability and fairness of the small group health insurance marketplace. The NAIC will continue to monitor the practices in this marketplace and will amend or add new provisions to this model law when warranted.

Improving Availability of Coverage

In conjunction with its work on rating and renewal practices, the NAIC is also investigating ways to improve availability of health insurance coverage for all small groups. Currently, in order to protect themselves against adverse selection,³ insurers medically underwrite small groups before accepting them. Groups that have sick or disabled employees or dependents often find it extremely difficult, or impossible, to get health insurance. Sometimes these groups deliberately exclude the sick individual from the group plan in order to obtain coverage for the remainder of the group. In addition, some insurers refuse to write coverage for groups in certain professions or occupations that they consider higher risk.

To address these problems of availability, the NAIC has formed a working group to develop model approaches to assure that all small employers have access to health insurance coverage, regardless of the health status or claims experience of the group or its workers. The NAIC currently is pursuing two approaches to assuring access, one based on a "reinsurance concept"⁴, and another is based on the "assigned risk concept"⁵ prevalent in property and casualty insurance.

Further, as part of its effort to assure availability, the working group also will adopt measures which would (1) require insurers to insure all eligible employees and dependents of a group; (2) require an insurer replacing group coverage to insure all employees and dependents that were previously insured; and (3) prohibit insurers from assessing new waiting periods or pre-existing condition exclusion periods when groups change carriers or when insured individuals change employers. Such provisions are important to prevent lapses in coverage and denial of coverage to certain group members because of their health status.

³ Adverse selection is the tendency of individuals with higher risk of loss to preferentially seek coverage.

⁴ Under a reinsurance approach, insurers can choose to reinsure high-risk individuals or groups (under set rules and premiums) with the reinsurance pool. The group will be charged a premium that is somewhat higher than average, but in most cases substantially lower than the premium needed to cover the group's losses. The extra costs are spread throughout the market through the reinsurance pool.

⁵ Under an assigned risk approach, insurers would be required to accept a certain percentage of high risk groups, based on their share of the small group health insurance market. A method of sharing the costs of abnormally high claims also would be included.

A number of states already have adopted provisions similar to these. The working group will release model language for comment at the NAIC Summer Meeting in June. We anticipate adoption of a final model act -- ready for enactment by all of the states -- later this year.

The goal of these approaches is to assure that individuals and groups are not denied needed coverage because of health problems. However, these efforts to guarantee availability of coverage will not lower the ultimate cost of health care coverage. Indeed, by providing access to higher risk groups and spreading the costs throughout the marketplace, health insurance premiums may increase. We will be working closely with representatives of small businesses to assure that these reforms fit their needs at a cost that can be borne within the system.

LEGISLATIVE ACTIVITY

The issues of health insurance market reform and access to health care have been widely considered in recent state legislative sessions. States have been active in adopting legislation to improve access to health care, including providing tax incentives to small business and modifying or eliminating benefit mandates in the small employer marketplace. In addition, more than a fifteen states have considered health insurance reforms, and at least six states already have adopted legislation similar to the NAIC Model law on rating and renewability of coverage. The NAIC staff has answered numerous questions from state legislative and regulatory offices about its initiatives, and we expect many more states to consider and adopt insurance reforms within the near future.

A number of insurance reform bills also have been or will be introduced in Congress this session. Given the substantial level of state activity in this area, the NAIC does not feel that federal intervention to set standards for insurance company practices is necessary or warranted. However, if national standards are necessary, the NAIC believes that state regulators should have primary responsibility for developing the appropriate standards. Further, implementation and enforcement of such standards should be at the state level.

One area where Congress should focus more attention relates to self-funded plans operating pursuant to the federal Employee Retirement Income Security Act ("ERISA"). While ostensibly a pension reform act, ERISA has permitted the health benefit plans of most large employers and collectively-bargained multiple-employer arrangements to operate in a virtually unregulated environment. These plans are exempt from virtually all state insurance laws, including those addressing unfair trade and claims practices; adequate notice to applicants and insureds; insurance rating, renewability and continuity of coverage provisions; guarantee fund and insolvency protection; and coverage requirements. Essentially, ERISA, which focuses on fiduciary responsibilities, contains no specific insurance-related regulatory standards to protect participants.

Indeed, it is somewhat puzzling that federal inquiries have been primarily focused at private insurers while ignoring the practices of federally regulated self-funded plans. Medical underwriting and experience rating can be used by these plans as well, including multiple-employer plans which affect small employers.⁶ While some federal proposals would apply their reforms to these ERISA self-funded plans (e.g., H.R. 1565),

⁶ These practices may become even more common as the result of a recent Department of Labor letter ruling, which permits self-funded collectively-bargained plans to market coverage to employers and employees outside of the collective bargaining arrangement.

others would not (e.g., H.R. 2121). If Congress is to act in this area, we feel that it would be highly inappropriate for it to establish standards for state regulated insurers while continuing to ignore the potential problems with federally regulated ERISA plans.

CONCLUSION:

The NAIC appreciates the opportunity to discuss needed reforms for health insurance. As insurance regulators, we feel that our role is to regulate the insurance marketplace so that it operates fairly and efficiently to provide coverage to the broadest possible group of individuals. We believe that the initiatives being undertaken by the NAIC are consistent with that role.

The NAIC hopes that its efforts will produce an insurance market that is fairer, more accessible, easier to understand, and more predictable. Most of the uninsured, however, do not have coverage because they or their employer cannot afford it. The costs of insurance primarily reflect the costs of health care services, which continue to soar. Addressing the critical issues surrounding affordability of coverage will require a broad and sustained societal effort.

⁷ As this Subcommittee well knows, the ERISA exemption, which fundamentally segmented the insurance marketplace, can be a barrier to effective reform. The inability to collect assessments from self-funded plans has substantially impeded the efforts of states to develop effective health risk pools for uninsurable individuals.

Chairman STARK. OK, help me, because the detail of your testimony surpasses my ability to understand some of the technicalities. If I said to you that my plan has no medical underwriting, continuous open enrollment, community rating, and a subsidy for high-risk or high-cost cases that would be done in the nature of a premium or per capita tax on every insured person in the country, including from self-insured firms, so that somebody in a huge ERISA plan with 20 year olds would still pay \$1 a head a year just like somebody with 60 year olds, how would that briefly differ from your model, and why is yours better or just different?

Mr. LYONS. I don't think in this room I am going to say my model is better than your model. I will probably just point out that our goals are the same. The goals that would be met with a successful program that you have described are the same goals that we are in fact seeking, as you can tell from my answers to the questions small business has.

We are trying to—

Chairman STARK. Are you suggesting then that perhaps your plan, just as a practical matter, taking into account business practices and politics, would be easier to accomplish than mine?

Mr. LYONS. Yes. One of the things that we understand—and I am speaking very frankly—we have 50 State legislatures involved here. If we can take the fight out of the issue and make substantial progress and give a bill to the States that they can pass, we are in good shape—

Chairman STARK. You are just better than I am at designing camels' noses, that is what you are telling me.

Mr. LYONS. Is the industry still here? Oh, no comment.

No, the issue though is that we are wondering what we can pull off practically in the industry, in the present market, without significant disruption, with still having the ability to control cross-overs. I don't know if you have ever seen the impact of adverse selection on an insurance company, but it is something awful to witness. You will have an insolvent company in a matter of months, not years, no matter how strong you are.

Chairman STARK. Almost as quickly as crooked operators like we have in California.

Mr. LYONS. Oh, that is another thing. When you had that magic wand before?

Chairman STARK. Yes.

Mr. LYONS. Can you wave it at First Executive? [Laughter.]

Chairman STARK. Or all the others who might market and be just like First Executive, if you made them—

Mr. LYONS. Not casting any general aspersions—

Chairman STARK [continuing]. The market value of their investment.

Well, thank you very much. I think NAIC's willingness to consort with the enemy here is commendable, and I assure you that any Federal regulation that impinges on your independence and authority will only be done in consultation with you, and I hope in such a way as to emphasize what State regulators can do far better than we can, but also to see how we can put some teeth in your enforcement arm and help you get some more compliance.

Mr. LYONS. Partnerships are always preferable. Thank you much.

Chairman STARK. Thank you very much.

In our fourth panel and I believe concluding panel, we will hear from the Association of Private Pension and Welfare Plans, represented by Alan Peres, who is the benefits supervisor for Ameritech, Inc.; and the ERISA Industry Committee, represented by Daniel P. Heslin, the corporate director of employee benefits at Rockwell International.

Do you both want to take my test?

Mr. HESLIN. Sure.

Chairman STARK. Can you outline for me what your health benefits are?

Mr. HESLIN. I would be glad to.

Chairman STARK. You could pass?

Mr. HESLIN. Yes.

Chairman STARK. You could pass? If you two guys couldn't pass, nobody could. OK, do you want to lead off, Mr. Peres?

STATEMENT OF ALAN PERES, MANAGER OF BENEFITS PLANNING, AMERITECH, ON BEHALF OF THE ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS

Mr. PERES. Thank you, Mr. Chairman. My name is Alan Peres, manager of Benefits Planning for Ameritech. I am here today on behalf of the—

Chairman STARK. Ameritech is a phone company?

Mr. PERES. Yes.

Chairman STARK. And its past name?

Mr. PERES. Ameritech is the Baby Bell for the Great Lakes region.

Chairman STARK. OK.

Mr. PERES. I am here today on behalf of the Association of Private Pension and Welfare Benefit Plans, the APPWP. Its more than 400 members include both large and small plan sponsors as well as plan support organizations. APPWP members directly sponsor or administer benefit plans covering more than 100 million Americans.

My comments today will focus on employer provision of health benefits, employer efforts to manage the costs of these benefits, and the effect that the Employment Retirement Income Security Act of 1974, ERISA, has on both the provision and management of these health plans.

This country has an extensive system of employer-provided health insurance, covering over 188 million Americans, including 88 percent of the civilian full-time work force.

Unfortunately, it is not extensive enough. There are roughly 34 million Americans without health insurance coverage. Two-thirds of them could be covered through an employer plan, and APPWP believes that employer coverage should expand to solve this problem.

We believe that employers are the right people to manage health insurance. They are better able than government to tailor health plans to the needs of their particular work forces, and they have

the flexibility to experiment with new ideas like changing health care delivery patterns and discover new ways to manage costs.

Employers can organize large groups that efficiently distribute risk, because these groups are formed through employment and not solely to purchase insurance. Employers also bring a business perspective and a concern about cost effectiveness to the health care system, and can act as knowledgeable purchasers to gain the greatest value for patients.

This public-private partnership is regulated largely under ERISA, which requires reporting and disclosure of health plan provisions, sets fiduciary standards, and provides private rights of action for participants to enforce benefit claims.

ERISA was intended to uniformly protect the benefits of plan participants and provide national standards for—

Chairman STARK. Are you sure about that, the benefit? This is interesting, if either of you are lawyers. We just had the insurance commissioner for the State of California in here yesterday, and ERISA is talking a walk on the beneficiaries insured by Executive Life on the theory that they aren't insuring the benefits, they are insuring the plan.

And so the minute the benefits were transferred to an insurance company, ERISA is walking away—it is an interesting point. Does ERISA insure that your employees will receive those benefits, or do they just insure that you are going to give it to them? Think about it. It is a trivia point, but for an employee who loses his benefits when, God forbid, Ameritech goes broke, that becomes very important. And ERISA is ducking it like any other insurance company.

Go ahead, I am sorry.

Mr. PERES. ERISA was intended to uniformly protect the benefits of plan participants and provide national standards for employers through the preemption of varying State insurance regulations and taxes.

The Supreme Court, however, ruled that ERISA preempted State law only for self-insured plans, while plans that purchase health plans through an insurance company remain subject to State insurance law and the added cost of State benefit mandates.

Over the last decade, increasing numbers of plan sponsors have dropped their insurance plans and elected to self-insure under ERISA's protection. While large employers have been most likely to self-insure, smaller employers—those with fewer than 500 workers—are the group that is now most aggressively converting to self-insurance.

At the same time, the total number of State mandates continues to grow rapidly. In fact, in the period 1989 to 1990, we saw the largest single enactment of new benefit mandates yet, 116 new laws, with only a few States enacting laws to the new mandates or provide small employers relief.

The trend to self-insurance may be putting small employers and their employees at risk. We believe small employers should be able to enjoy the same advantages that larger employers derive from State pools and self-insurance—risk spreading, access to managed care plans, and protection from State benefit mandates without having to self-insure.

We are concerned about legislation introduced to overturn the Pilot Life decision because it would reinforce the separate treatment of insured and self-insured plans. My written testimony refers to this at some length.

Other bills recently introduced by members of this subcommittee would deal with the problem of State-mandated benefit laws by creating uniform standards for health plans issued by insurance carriers. APPWP plans to submit detailed comments on these bills to the subcommittee once its own committees have had a chance to review them.

In general, APPWP welcomes the efforts of these two bills to improve the availability and affordability of health insurance to small employers by reforming the market for small group health insurance.

APPWP supports proposals aimed at setting contractual standards that would help continue coverage of small employers, limit new pre-existing condition restrictions when changing insurance carriers, curtail premium increases, and create a privately funded and administered reinsurance mechanism for high-risk persons.

We believe that these standards should apply uniformly nationwide, and should not be adopted on a State-by-State basis. We are concerned, however, with efforts that would go beyond contractual issues and would regulate the benefits including employee benefit plans.

The fundamental problem for the small group market as well as for large groups is the lack of control over rising health care costs. Over the last quarter century, public and private efforts to control health care costs have had little effect on the consistent rapid growth in national health expenditures.

For employers, these increases have been particularly severe in the 1980's, as government has shifted its cost to business. As a result, business' share of national health spending has grown from 19 percent in 1967 to 30 percent in 1989.

In the absence of successful national cost containment initiatives, employers have focused on developing a range of managed care strategies to control the costs of their own health plans. These evolving strategies include the use of utilization reviews, selective contracting, alternative delivery systems like HMO's and PPO's, point-of-service options, case management, and other techniques aimed at managing the use of services by plan participants. We are learning and improving these as we go along.

Unfortunately, employer and insurer innovations in managed care are increasingly encountering resistance from provider interest groups and growing efforts by State legislatures to limit managed care practices.

We believe the continued enactment of State antimanaged care laws will tie employers' hands in the effort to control their health care costs and contribute to an escalating level of health care expenditures in the system as a whole.

We support the proposal in H.R. 1567 to preempt State laws that would interfere with the operation of managed care activities. Our member experiences show that managed care can help control a company's soaring costs while enhancing the quality of health care for employees.

Managed care, though, is not the exclusive answer to rising costs in an environment where government spends 40 percent of health care dollars, government costs are increasingly shifted to private payers, and changes in technology, demographics, and utilization contribute to rising health care expenditures.

Chairman STARK. Why is it always me? Why doesn't General Electric in Schenectady shift just as much costs onto the Medicare system as I might shift onto the cost in Milwaukee for Medicare? I mean, if you have a big private employer, Ford in Dearborn, arguably they can shift more costs than a government plan.

I mean, I am willing to agree that Medicare may very well shift some costs, but I don't think you can take humongous employers who may have a very dominant position in a market and say they don't shift as well. Isn't that fair?

If you are managing care, which is basically buying smart or tough, why are you any different? Depending on our share of the market in an area—Medicare may do far better in Florida—but in a young community like Silicon Valley, you have to figure that Hewlett Packard is shifting more costs than I am.

Mr. PERES. Well, I think the difference is that the government does it by legislation. You set how much you are going to pay and how much has to be accepted by the hospital, by the doctor for reimbursement.

Chairman STARK. Not the doctor.

Mr. PERES. All right. Increasingly, though—

Chairman STARK. We are trying, but—

Mr. PERES. You are trying, OK.

Chairman STARK. You should join with me, and we will both save some money.

Mr. PERES. For private payers like ourselves, we deal our case, through Blue Cross plans. They negotiate on our behalf, on behalf of all their clients. Not every provider, not every hospital, not every doctor, is going to be willing to accept that. If they don't want to, they don't have to, and—

Chairman STARK. I understand that, but—

Mr. PERES [continuing]. And that is the difference as I see it.

Chairman STARK. Arguably, I suppose, some hospitals or doctors could refuse Medicare patients, but why would a physician in Dearborn refuse a Ford employee? One person's managed care is somebody else's cost shifting, basically.

I just wanted to say that we are both in this box together, all right?

Mr. PERES. OK. I will just summarize.

A national program to manage the cost of providing health care should end cost shifting to private payers, expand the use of managed care, particularly to small employers and government plans, provide broader risks of preemption of State laws effecting benefits and coverage under employee benefit plans, including State benefit mandates, encourage greater employee involvement in decisions about health insurance and health care, expand outcomes research and use of the results through physician protocols and national technology assessment, reform medical malpractice liability, and expand employer-based health insurance without the use of mandates or health benefit taxation.

Thank you, and I will be pleased to answer any further questions that you may have.

[The prepared statement follows:]



**TESTIMONY OF
ALAN PERES
MANAGER OF BENEFITS PLANNING, AMERITECH**

Mr. Chairman and Members of the Committee

I am Alan Peres, Manager of Benefits Planning for Ameritech. Ameritech is one of the seven regional communications companies formed as a result of the breakup of the Bell System. In 1989, our net income was \$1.2 billion. The company has 76,000 active employees, predominantly in five states: Illinois, Indiana, Michigan, Ohio, and Wisconsin. In addition, we have 45,000 retired employees. Ameritech provides medical coverage to all active and retired employees and their dependents -- approximately 250,000 people in total. We spent \$337 million in 1989 and \$373 million in 1990 on health care.

I am here today on behalf of the Association of Private Pension and Welfare Plans (APPWP), a non-profit organization founded in 1967 to protect and foster the growth of America's private employer-sponsored employee benefit system. Its more than 400 members include both large and small plan sponsors as well as plan support organizations such as investment firms, banks, insurers, actuarial firms, consulting firms and other professional benefit organizations. APPWP members directly sponsor or administer pension and health benefit plans covering more than 100 million Americans. All of the APPWP members provide health insurance for their employees, and most, but not all, members are self-insured.

My comments today will focus on employer provision of health benefits, employer efforts to manage the costs of these benefits, and the effect that the Employee Retirement Income Security Act of 1974 (ERISA) has on both the provision and management of these health plans.

Employer Sponsorship of Health Benefits Works

Employer-sponsored health plans have evolved over the years to become the most significant source of private health insurance coverage in the United States. Over 188 million Americans - including 80 percent of the civilian full-time workforce - are today covered through an employer plan. As extensive as employer-based coverage is, approximately 34 million Americans are still left without health insurance coverage, largely due to high and rising health care costs. The fact that two-thirds of the uninsured have a direct or indirect employment relationship argues for an expansion of the employer-based system to achieve the goal of universal health care coverage in America.

The substantial role of employer plans in our system is by itself a good argument for continuing to organize health care financing through employers. The costs, dislocations, and redistribution of risk that would result from changing this role are so substantial that it seems hardly practical to consider a complete restructuring of this role in our time.

Our reliance on employers to organize health insurance coverage is not an accident, and there are a number of sound reasons for maintaining this system of health insurance. One is that employers are more able than governments to tailor health plans to the needs of their particular workforces. This capacity to quickly design or modify health benefits also contributes to the employers' unique ability to experiment with new ideas in providing benefits, to modify benefits to meet changing health care delivery patterns, and to discover new ways to manage the

cost of health benefits. Over the course of your hearings you have heard considerable testimony from employers reflecting the innovation and energy that is being channeled today into improving the management of health benefits.

Employer provision of health benefits is also an effective way to organize large groups that efficiently distribute risk. When individuals are free to form groups for the purpose of purchasing health insurance, they inevitably organize themselves on the basis of risk -- low risk individuals form pools to purchase the lowest cost insurance, and high risk individuals are left with high cost or no insurance. Having individuals acquire health insurance through employment ensures that their participation in health insurance groups is motivated by factors other than the cost of health insurance and thus not an interference with the random assignment of health risk.

Employers also bring a business perspective and a concern about cost-effectiveness to the health care system. Employers can operate as knowledgeable purchasers to gain the greatest value for patients from health services they purchase. While it is also possible for government to act as a knowledgeable purchaser on behalf of patients, it is a more difficult role for a political entity that must be responsive to a variety of constituencies in addition to the patients themselves. Government's concerns about health care resource limitations may be diluted by conflicting concerns about provider opportunities.

Finally, employer provision of health benefits is a bargain for the federal government. For every dollar of services the government would otherwise finance, the government spends only \$0.19 on average if the employer provides the service, according to estimates by Sylvester Schieber in APPWP's study on benefits and taxation titled: Benefits Bargain: Why We Should Not Tax Employee Benefits. Thus the government can achieve goals of broad health insurance coverage without having to tax and spend the bulk of the revenue it would need to provide health insurance directly.

In short, we believe the social policy aims of providing affordable financing for high quality health care services can be met most effectively if the government continues to rely on employers to provide health insurance for the preponderance of workers and their families in the United States.

ERISA provides the Framework for Employee Benefits

Employer responsibilities and employee rights in the provision of employee benefits are governed by the Employee Retirement Income Security Act of 1974 (ERISA). The relationship of ERISA to health benefits is not always well understood, and ERISA has often been credited or blamed for a variety of health care consequences not directly related to this Act.

ERISA is in its essence a broad umbrella of protections for participants in employee benefit plans, including health plans. For health benefits, ERISA requires plans to report and disclose plan provisions to the federal government and to plan participants, sets standards of fiduciary responsibility, provides participants with private rights of action to enforce their claims to benefits, and requires the opportunity for continuation of coverage under group health plans after

termination of employment. For pension benefits, ERISA provides additional standards for participation and vesting of benefits and funding of pension plans, as well as a system of pension plan termination insurance.

ERISA's regulatory framework for health plans has not been as specific as its framework for pension plans for a number of reasons. First, the focus of the Congress when ERISA was enacted was largely on the financial solvency of pension funds. Driven by a few significant pension failures, the Congress was intent on setting standards for pension funding and asset investment, and on creating insurance for pension benefits to secure promised retirement income. Not only was health a much smaller obligation at the time, but health benefits were a current and not a future obligation, and thus funding was not a concern.

Second, other pension issues, such as coverage and benefit equity, were less of a concern with health benefits, because health benefits cover a much broader group of employees than pensions, and health benefits tend to be quite uniform for workers at all income levels.

Third, the framers of ERISA recognized that benefit equity was much simpler to determine with regard to pensions, which are monetary payments, than with health benefits which reflect a variety of health services having very different values for persons in different circumstances. To define and measure the value of health benefits is to make judgments about the need and use of various services, and ultimately about health care priorities. It is not a matter to be undertaken solely in a benefit regulation context.

ERISA Preemption of State Laws Provides Consistency

In order to maintain consistent treatment for participants of plan sponsors operating in a number of states, ERISA (under section 514) broadly preempts "any and all" state laws related to employee benefit plans. While this section went on to exclude state laws regulating insurance, banking or securities from ERISA preemption, it further specified that employee benefit plans are not to be deemed to be insurance, banking or investment companies for the purpose of state regulation.

The Supreme Court, in Metropolitan Life Insurance Co. v. Massachusetts (105 S.Ct. at 2389), interpreted section 514 of ERISA to create two separate classes of employee benefit plan: "self-insured" and "insured". Under the court's distinction, ERISA governs self-insured health plans -- plans in which a plan sponsor bears the risk for employees' health costs, though they may purchase administrative services only (ASO), stop-loss protection, or minimum premium plans (MPP) from an insurance company. State insurance laws apply to plans that are entirely purchased from insurance companies.

The single nationwide regulatory framework that is provided through ERISA preemption is a necessity for companies, such as many APPWP members, that operate employee benefit plans in more than one state. ERISA has enabled these multi-state employers to avoid having to separately qualify or meet divergent state requirements with a single plan in a multiplicity of jurisdictions. It has also protected participants by setting uniform standards for the financial operations of employee benefit plans and providing participants with uniform private rights of action to ensure that benefits are paid.

The limitation of ERISA's nationwide regulatory structure to self-insured health plans has left insured plans subject to added costs imposed by state premium taxes and mandated health benefits. The advantage of experience rating a large group and managing its health care costs added to the protection from state taxes and mandated benefits afforded by ERISA preemption has encouraged large numbers of plan sponsors to drop their insured plans and seek ERISA's protection through self-insurance over the last decade. Today, health plans in which an employer has assumed all or part of the risk (e.g. ASO, MPP or stop loss plans) account for 55 percent of total commercial insurance business. While self-insurance is most typical among the largest employers, a recent survey by benefits consultants A. Foster Higgins & Co., Inc. indicates that small employers (those with fewer than 500 workers) are converting to self-insurance at the most rapid rate.

Those plan sponsors that cannot self-insure, for one reason or another, particularly the smallest businesses, are left behind to cope with state regulation, including the increasing burden of state mandated health benefits. State mandates reduce the flexibility that plan sponsors have to meet employee needs and control costs. They impose additional costs by requiring that plans cover specific benefits (such as invitro fertilization, anti-abortion or long term care); pay groups of non-physician providers (such as chiropractors, podiatrists, naturopaths or acupuncturists); or insure specific participants (such as non-custodial children or dependent students).

Although proponents have argued that mandating benefits can reduce costs - for example by substituting lower-paid health professionals for physicians - the experience with most mandated benefits has been that they increase costs by requiring payment to new practitioners for categories of services not previously covered. A study by HIAA of health insurance costs in Maryland in 1986 concluded that, overall, state mandated benefits raised the cost of family coverage by 17 percent.

Despite a growing concern about state benefit mandates, the total number of mandates in force in the fifty states continues to grow rapidly. The number of benefit mandates in effect has risen from fewer than 200 in the mid 1970s to 816 as of 1990, according to the Blue Cross and Blue Shield Association. In fact, the most recent two year period, 1989-90, has seen the largest single enactment of new benefit mandates yet -- 116 new laws. In all, there now are more than 50 different types of mandated benefits in force, with as many as 35 mandates in effect in the most mandate-prone states. The variability in benefit mandates from State to State itself adds costs. Insurers who market plans in more than one State tend to incorporate the sum of all mandated benefits in the States in which they operate in order to provide uniform plans for their customers.

While the overall trend is still toward more mandates, a few States have begun to respond to concerns about state benefit mandates by enacting a series of "anti-mandate" laws. In the last few years, sixteen states have enacted laws requiring an evaluation of the financial and social impact of additional mandates as a condition for enactment. Three states prevent mandates from applying to insured plans until they also apply to self-insured plans. Nine states have enacted mandated benefit waivers to enable insured plans for small groups (25 to 50 or fewer) to meet a lower minimum state standard and avoid mandated benefits.

We believe that it is an unfortunate result of the limitations placed on ERISA that plan sponsors decisions to

self-insure are motivated more by the need to escape burdensome state requirements than by a judgment that self-insurance is the most effective way to bear health risks and manage health insurance costs. Not all employers are large enough or have good enough risks to self-insure.

Small employers should have the same advantages that larger employers can derive from large pools and self-insurance -- risk spreading, negotiating discounts with providers, and protection from state benefit mandates. While a variety of pooling arrangements have been tried for small employers, they have often been unable to overcome the adverse selection problems that arise from the voluntary association of separate risk groups.

Employers too small to self insure may have some of the advantages of pooled risk, preemption of State mandated benefits, and managed care by joining multiple employer welfare arrangements (MEWAs). However, an uncertain regulatory environment continues to restrain the use of MEWAs. ERISA section 514 (b)(6) places MEWAs under state insurance regulation with regard to the adequacy of reserves and contributions. Some States have used this regulatory authority to set reserve requirements that effectively prevent MEWAs from forming. Other States have left MEWAs unregulated, contending that they are preempted by ERISA. Some uniform approach to defining and regulating these voluntary associations is necessary if small businesses are going to have an effective mechanism to benefit from the risk pooling of large self-insured plans.

APPWP believes a better solution is to extend the protections afforded under ERISA to all employee benefit plans - whether insured or self-insured - and clearly limit the state regulatory involvement to insurance reserve requirements and consumer protections. Preemption of State benefit mandates should apply to the health benefit plans of all employers. If that is not possible, the Congress should at least give small businesses nationwide waivers from state benefit mandates similar to the state-based waivers already in effect in nine states.

Laws to Restrict ERISA Preemption Are Misdirected

APPWP is particularly concerned about bills introduced in the House and Senate this year aimed at sheltering a class of State law from ERISA preemption. The proposed legislation is a response to the U.S. Supreme Court's decision in Pilot Life Insurance Company v. Dedeaux (481 U.S. 41 (1987)) in which the court ruled that ERISA preempted state common law causes of action. Dedeaux's claim against Pilot Life for failure to pay benefits was brought under State general contract law. The Court ruled that these laws did not specifically regulate insurance within the meaning of ERISA's "saving clause" (section 514 (b)(2)(A)) and were thus preempted by ERISA, and that ERISA's civil enforcement provisions were the exclusive remedy for insured as well as self-insured plans.

H.R. 1602, introduced by Rep. Berman (D-CA), would add a new clause to ERISA section 514(b)(2)(A) to "save" from preemption state statute or common law that provides a remedy for unfair insurance claims practices against insurance companies or other insurers.

APPWP is concerned about bills that would specify additional statutory limits for the application of ERISA preemption. Restrictions in ERISA preemption that would expand State regulatory authority over employee benefit

plans would impair the ability of employers to design uniform plans and manage them effectively to meet the needs of their workforces. It would also raise questions about the uniform application of private rights of action now available under ERISA. In particular, H.R. 1602 would expand the separate treatment now accorded insured and self-insured plans, and raise the costs of insured plans by exposing their managed care efforts to significantly greater liability under State common law.

Uniform Standards for Insured Plans (H.R. 2121/H.R. 1565)

Two bills have been introduced recently by Members of this Subcommittee that would override State mandated benefit laws by creating uniform standards for health plans issued by insurance carriers -- the "Health Insurance Reform Act of 1991" (H.R. 2121) and the "Health Equity and Access Reform Today (HEART) Act" (H.R. 1565). Both bills would impose an excise tax on insurance carriers marketing plans that were not in compliance with the standards. In the case of H.R. 1565, States would adopt and enforce standards set by the National Association of Insurance Commissioners (NAIC) that would apply only to plans offered to small employers (3 to 25 employees), and excise taxes would be imposed only in non-complying States. H.R. 2121 would create Federal benefit and contractual standards for all insurance contracts and would tax non-complying carriers.

APPWP plans to submit detailed comments to the Subcommittee once its own committees have had a chance to review these bills. In general, APPWP welcomes the efforts of these two bills to improve the availability and affordability of health insurance to small employers by reforming the market for small group health insurance. APPWP supports the reform proposals advanced by the Health Insurance Association of America (HIAA) to help continue coverage of small employers, limit new pre-existing condition restrictions when changing insurance carriers, curtail premium increases, and create a privately funded and administered reinsurance mechanism for high risk persons. To the extent that standards are developed, they should apply uniformly nationwide, and should not be modified on a state-by-state basis.

APPWP, however, is concerned with efforts that would go beyond contractual issues and would regulate the benefits included in the employee benefit plans. To the extent that one set of benefit standards is created for insured plans to replace existing state benefit mandates, these new standards simply reinforce the distinction and cost difference that has arisen between insured and self-insured plans and encourage a continuing movement to self-insurance as a solution to controlling costs.

Rising Health Care Costs Threaten Employer Role

If there is a threat to the continued involvement of employers in the provision of health care benefits, it results from the lack of control over rising health care costs. The rapid growth in national health expenditures that has continued over the last quarter century has been largely unaffected by public or private efforts to control costs. Business, consumers, and government alike have experienced rising costs driven by a number of factors including the explosion in technology, incentives to overutilize care and to provide unnecessary care, and population aging.

In addition to systemwide increases, there has been a steady shifting of health costs to business that has resulted in the business share of national health spending growing from 19 percent in 1967 to 30 percent in 1989 (according to an article by Katharine Levit and Cathy Cowan in the Winter 1990 issue of Health Care Financing Review). As a result, business costs have grown at twice the rate of overall medical inflation, pushing up health insurance premiums by as much as 20 to 50 percent a year in recent years.

The nationwide problems of accelerating corporate health care costs and growing cost shifting to business, in part caused by government policy to underfund Medicare and Medicaid, has not been met with a comparable government effort to develop national cost containment solutions. Employers, applying their own creativity and sensitivity to the needs of their workforces, have focused on controlling the costs of their own health plans through a variety of ingenious strategies. Much of this innovation by large self-insured companies and insurers has focused on managing the use of services by plan participants, all under the heading of "managed care". These concepts continue to evolve - providing one more example of the adaptability that is inherent in a multiple payor system.

Managed Care Can Effectively Control an Employer's Costs

The experience of our member companies with managed care initiatives teaches two conclusions. First, managed care can help control a company's soaring costs while enhancing the quality of health care for employees. Second, in an environment where forty percent of health care costs are paid by government programs, individual efforts to control costs cannot overcome the effects of government cost-shifting to private payors, nor can a system of unrelated or competing individual efforts be effective in controlling overall national health care expenditures.

APPWP's recent publication Second Opinion: Employers Can Make Managed Care Work provides four examples of member companies whose managed care programs have helped control costs without sacrificing quality. Southwestern Bell Corporation's (SBC's) CustomCare plan was introduced in 1987 in response to a 217 percent increase in its health care costs between 1979 and 1985. CustomCare incorporates networks of qualified health care providers developed by SBC's insurance carrier in 13 metropolitan areas where 65 percent of SBC's employees and retirees live. Employees who use services at the direction of a participating primary physician pay a \$10 copayment for the first office visit and no copayment thereafter. Employees have the option of using non-network providers on a service-by-service basis, but must pay a \$350 deductible per person (up to 3 persons) and a 20 percent copayment. While CustomCare was effective in reducing aggregate costs 8.9 percent below the trendline expected when it was introduced, SBC continues to monitor and improve the plan. Indeed, continual monitoring and improvement is the essence of "managing" care, rather than simply containing costs.

Allied-Signal implemented its Health Care Connection Plan beginning in 1988 for 113,000 employees and dependents in 26 health care networks across the country. The year before Allied-Signal's plan was introduced, its health care costs increased by 39 percent. The plan Allied-Signal introduced provides financial incentives for participants to choose network providers at the "point-of-service". Participants who choose a network primary care physician pay a \$10 copayment for an office visit and a \$5 copayment

for prescription drugs. Participants choosing non-participating physicians pay a 1 percent of pay deductible (3 percent for a family) and 20 percent coinsurance on remaining bills. Allied-Signal contracted with a major insurance carrier to design a single program nationwide, using 26 networks serving the majority of Allied-Signal employees, dependents, and retirees, and eliminating HMOs and other alternative plans. The insurer has guaranteed Allied-Signal three years of single digit inflation in premiums, and bears the risk for all health care inflation in excess of that amount. Utilization of the networks by Allied-Signal employees has been high - about 75 percent use the networks 95 to 100 percent of the time. Cost increases under the contract will remain below Allied-Signal's earlier trendline.

First Interstate Bancorp initiated its "point-of-service" Health Span plan with a network of contracted providers in 1989. In the year preceding its implementation, First Interstate's costs increased 35 percent. Health Span began by covering 75 percent of First Interstate's workforce. Participants could choose at the time they need care whether to use its network of contracted physicians and hospitals or use non-participating providers, with the plan paying 70 percent of reasonable and customary covered charges after a deductible of \$250 (individual) and \$750 (family). Participants using the Health Span network select a personal care physician, and all patient care is subsequently directed by that physician. Since 1989, First Interstate has been steadily expanding its network.

A different approach to managed care is provided to several APPWP members through a insurance carrier program of utilization management known as Healthline. Healthline uses carefully developed physician protocols and active case management to reduce unnecessary medical care and improve the appropriateness of procedures. Healthline blends pre-admission screening for inpatient care, on-site nurse management with reviews of patient records and patient visits, managed mental health care using a preferred provider organization and case management, outpatient pre-reviews with physicians, and protocols for surgery.

At Ameritech, we have kept our average annual increase in health costs to 10.4 percent over the last five years through concerted care management efforts with our local Blue Cross plans. Under the current plan, Blue Cross reviews medical care received by our employees and their dependents. All elective hospital procedures are reviewed prospectively for appropriateness of procedure and for site of service. All admissions, whether urgent or elective, are reviewed for appropriateness of continued stay. Patients also receive valuable assistance in selecting treatments and providers to ensure a high quality of care. Our plan provides employees the option of using a preferred provider network with financial incentives to use physicians and hospitals who have agreed to participate in the medical management programs and accept negotiated fees. We recently announced that employees will be offered a new "point of service" medical plan that will provide access through a primary physician to a broad package of medical benefits with the option of using a non-network provider at the point of service for a higher out-of-pocket payment.

In all of these instances, employers and insurers are experimenting with alternative approaches to managing employee utilization of health care, selecting qualified providers, and reducing unnecessary medical care to control costs.

Although, APPWP is not prepared to comment on the details of the proposed tax incentives for managed care in H.R. 1565, APPWP supports the effort of the bill's sponsors to encourage broader use by employers of known successful managed care techniques.

State Anti-Managed Care Laws May Interfere

Unfortunately, employer and insurer innovations in managed care are increasingly encountering resistance from provider interest groups and growing efforts by State legislatures to limit managed care practices. Several States have passed or are considering laws that would limit utilization review, restrict the formation of provider networks, or require "freedom-of-choice" of pharmacies (preventing use of mail order or formularies) for prescription drug purchases.

Utilization review limitation includes efforts to restrict the use of non-local medical protocols, impose credentialing or residency restrictions on physicians performing utilization review, prohibit utilization review of psychiatric, chemical dependency or chiropractic treatment, or impose stringent appeal requirements. Network restriction and "freedom-of-choice" efforts would limit the use of selective contracting, the exclusion of non-network providers, and the negotiation of reimbursement discounts.

Laws that would prevent payors from holding providers to accepted standards of practice and restrict payor reviews of reimbursement claims interfere with efforts to reduce unnecessary and inappropriate medical care. APPWP believes the continuing enactment of State "anti-managed-care" laws will tie employers' hands in the effort to control their health care costs, and will contribute to an escalating level of health care expenditures in the system as a whole. We support the proposal in H.R. 1565 to preempt State laws that would interfere with the operation of managed care activities.

APPWP Recommends A National Effort to Control Costs

APPWP believes that effective control of the growth in national health expenditures requires a national cost management policy. This policy should build upon the existing employer-based, multiple payor system, and encourage a reliance on managed care techniques to eliminate unnecessary medical care and improve the quality of care for patients.

A national program to manage the cost of providing health care should include:

- 1) An end to cost shifting from government to private payors and among private payors through an improvement in Medicaid payment rates and through opportunities for private payors to benefit from Medicare methods in the payment of providers;
- 2) Efforts to expand the use of managed care techniques to all health plans - particularly to develop methods to extend managed care to small employers - including government plans, and Federal preemption of State anti-managed care laws;
- 3) Broad ERISA preemption of State laws affecting benefits and coverage under employee benefit plans, including state benefit mandates;

- 4) Efforts to increase the involvement of employees in selecting and paying for health care coverage through greater cost sharing and education;
- 5) Additional Federal resources to improve the quality of health care through an expansion of research in medical outcomes, and an effort to improve the use of outcome information in treatment and coverage decisions, including the development of physician protocols and national technology assessment;
- 6) Medical malpractice reform, including the development of standards of negligence and treatment practice guidelines, the use of arbitration, limits on punitive damages.
- 7) Expansion of health insurance coverage should build upon our employer-based system without resorting to the use of rigid employer mandates or the disincentives of taxes on health benefits.

Conclusion

Employer-provided health benefits today meet the needs of most of the working population and their dependents. Employers have the flexibility to tailor benefits to specific needs of their workforces and manage these benefits to insure efficient, high-quality health care. This system works well for 80 percent of the employed population and should expand to meet the needs of as many uninsured Americans as possible through their employment relationship.

ERISA provides the regulatory framework for health benefits. ERISA was intended to uniformly protect the benefits of plan participants and provide national standards for employers through the preemption of varying State insurance regulations and taxes.

The Supreme Court recognized a distinction between self-insured plans and plans that purchased insurance through an insurance company, and that distinction has led to two classes of health plans. Self-insured plans, operated primarily by large employers, can avoid State benefit mandates and have a cost advantages over insured plans, primarily purchased by small employers, which are subject to State benefit mandates and other aspects of insurance regulation. This differential is creating an incentive to self-insure that may lead to arrangements that are harmful for employers or for employees. APPWP believes small business should have access to the same health insurance arrangements to pool risk, manage care, and avoid State benefit mandates that are currently available for large employers.

Managed care provides employers an opportunity to improve the efficiency and quality of health care provided to their employees. The flexibility and pluralism in our existing employer-based multiple payor system has been instrumental in the innovative development of alternative managed care strategies. Efforts to develop new managed care approaches should be encouraged, and small employers should have an equal opportunity to benefit from managed care techniques. In addition, an effort should be made to protect employer plans from State laws that would impair the ability of employers to select providers, review utilization, or otherwise manage health care.

Managed care is not the exclusive answer to rising health care costs in an environment where the government

pays nearly half of the bill, and changes in technology, demographics, and utilization influence the growth in health care costs. APPWP urges the Congress to develop a national policy to control health care costs that addresses all dimensions of the problem and applies to all payors in the health care system - public and private alike.

Chairman STARK. Thank you.
Mr. Heslin.

STATEMENT OF DANIEL P. HESLIN, CORPORATE DIRECTOR, EMPLOYEE BENEFIT PROGRAMS, ROCKWELL INTERNATIONAL CORP., ON BEHALF OF THE ERISA INDUSTRY COMMITTEE

Mr. HESLIN. Thank you. I represent the ERISA Industry Committee today, sir.

Major employers have a strong interest in providing health care coverage to employees and their dependents. Health care coverage is an investment by an employer in the quality, productivity, and economic security of its work force. For every employer and employee, the quality and cost of health care are primary concerns.

ERIC members believe that building consensus for health care system reform must begin with the goal of improving the quality and reducing the cost of health care.

All Americans should have access to basic health care. While the vast majority of Americans have coverage from one or more sources, our current health care system falls short of providing coherent, efficient, and cost-effective basic health care to all Americans.

The major deficiencies of the U.S. health care system are well known. First, billions of dollars are wasted on inappropriate or poor quality health care each year. Second, government is failing to meet its obligation to provide coverage to the poor and the near-poor. Third, and most important, the rapidly escalating cost of health care is forcing both private and public payers to reduce coverage and to attempt to shift costs to other payers.

As a result, millions of Americans lack access to basic health care. The U.S. health care system in its present form lacks the capacity to remedy these shortcomings.

ERIC suggests that creating a consensus for health care system reform requires four essential steps. First, we must redefine health care as a product that, by design, eliminates inappropriate care and unjustified variation in practice patterns.

Second, we must restructure the health care marketplace by replacing current incentives that reward high-volume, high-cost providers with incentives that reward high-quality providers.

Third, we must reallocate financial responsibility for health care to assure that all payers, including government payers, contribute their fair share to the cost of care.

And fourth, we must allocate resources to provide consistently high quality basic health care throughout the system.

If we can slow the growth of systemwide cost increases, expanding access to health care coverage will be more feasible. Until the health care product and marketplace are redefined, however, proposals for expanded access will fail to generate broad support, and if enacted will prove to be an empty promise.

Development of a comprehensive health care policy does not necessarily require us to replace the current mixture of public and private sources of coverage with a single national program. It does require the development of a broad-based strategy to restructure the dysfunctional health care system. It also means that incremental

approaches must be abandoned in favor of policies that simultaneously address quality, cost and access.

For example, in the absence of consensus for any of the comprehensive reform proposals currently on the table, some have proposed to address problems in the private group health insurance market without waiting for broad-based reform. Such proposals often address the most glaring gaps by concentrating on the problems of small employers.

While these reforms might bring needed improvements in the group health insurance market for small employers, they are likely to increase the average cost of insurance for many individuals and businesses.

In an effort to make coverage more affordable, current proposals often rely on a basic benefit package and subsidies of reinsurance mechanisms by large employers to lower insurance costs for small employers. Neither basic benefit packages nor subsidized reinsurance pools attack the real problem, the escalating cost of health care and our disorganized health care delivery system.

Our goal must be to slow the growth of total expenditures, not merely to design down plan coverages or to shift costs among payers.

Focusing Federal debate on reform of the group health insurance market diverts attention from the fundamental need for comprehensive reform of the health care system as a whole.

Both H.R. 2121, introduced by you, Mr. Chairman, and H.R. 1565, introduced by committee members Johnson and Chandler, fail to address the needs of the health care system on a comprehensive basis. While each is an important step toward developing consensus, neither addresses the fundamental problems we face.

For these and other reasons described in detail in our written statement, ERIC cannot support either of these bills in their current form.

In conclusion, ERIC believes that before we can expand access to health care, the current health care system must be made more coherent, efficient, and cost-effective.

Any legislative proposal should, at a minimum, incorporate the following four elements: A comprehensive framework for simultaneously addressing quality, cost, and access in the health care system; a coherent strategy for eliminating unnecessary care and containing medical cost inflation for the health care system as a whole; a coherent strategy for distributing health care costs among individuals, employers, and government on an equitable basis, including the elimination of cost-shifting among payers; and an opportunity for major employers to continue to be the primary source of health care for employees and their dependents.

Thank you.

[The prepared statement follows:]

STATEMENT OF DANIEL P. HESLIN
ON BEHALF OF THE ERISA INDUSTRY COMMITTEE

Good morning. My name is Daniel Heslin. I am Corporate Director, Employee Benefit Programs, for Rockwell International. I am testifying on behalf of The ERISA Industry Committee (ERIC).

ERIC is an association representing the retirement security and employee benefits interests of more than 125 of the nation's largest employers. Virtually all of these companies employ more than 10,000 employees and a number of them have hundreds of thousands of employees. As sponsors of health, disability, pension, savings, life insurance and other benefit plans directly covering approximately 25 million participants and beneficiaries, ERIC's members have a strong interest in the success and expansion of the employee benefit plan system in the private sector. All of ERIC's members provide comprehensive health care coverage to their employees. Together, they provide coverage to about 10 percent of the U.S. population.

Like other associations with an interest in health care, ERIC has formed a senior-level task force of its members to examine health care system reform issues. I am a member of the ERIC Health Policy Task Force, as well as a member of ERIC's Board of Directors. The goal of ERIC's Health Policy Task Force is to identify principles of reform that will lead to a coherent, efficient and cost-effective health care system. We are working hard to examine the full range of issues implied by this task. My testimony reflects the methods we are using to address the real problems in our health care system, not just the symptoms.

As sponsors of benefit plans that set the standard for comprehensive employment-based coverage, ERIC's members have a significant stake in the reform debate. In fact, our stake is so large that we cannot refrain from actively participating in the debate. It takes time to develop consensus among our members, however, when the issues are so complex. Since ERIC's efforts are ongoing, the views expressed in this testimony are subject to change as we continue to study a very complex and dynamic array of problems.

My remarks today will focus on congressional proposals to reform private group health insurance markets, the impact of the proposals on employers who provide benefits under the Employee Retirement Income Security Act of 1974 (ERISA) and the implications of the proposed reforms for major employers.

I. MAJOR EMPLOYERS' INTEREST IN PROVIDING HEALTH BENEFITS TO WORKERS AND THEIR DEPENDENTS:

Major employers have a strong interest in providing employment-based health care coverage to employees and their dependents:

- ◆ to ensure a healthy and productive work force;

- ◆ to respond to workers' concerns about economic security and their ability to afford adequate health care; and
- ◆ to offer health benefits as part of a competitive compensation package that will attract and retain valued workers.

Thus, an employer's employee benefit arrangements reflect the specific needs of its work force. Benefits are often tailored to meet geographic differences or demographic factors within a single company. In other cases, employer and employee needs may require a unified system throughout an employer's organization.

The vast majority of Americans under the age of 65 receive health care coverage through employer-sponsored plans. ERIC members have set the standard for comprehensive employment-based health care coverage. For every employer and every employee, quality and cost are primary concerns. Thus, building consensus for health care system reform must begin with the goal of improving the quality and reducing the cost of health care. Proposals to expand access -- either by mandating employer-provided coverage or by replacing the employment-based system with a single-payer alternative -- without paying attention to the quality or cost of health care, offer little or nothing to this mainstream constituency.

Before I address specific concerns about proposals to reform private group health insurance markets, and the impact of such reforms on health care plans under ERISA, I would like to review the U.S. health care system from the perspective of major employers.

II. OVERVIEW OF THE U.S. HEALTH CARE SYSTEM:

Our health care system as a whole -- that is, government benefit programs, employer-provided coverage, nonemployment-based coverage purchased directly by individuals and out-of-pocket expenditures -- is intended to provide basic health care to all Americans. ERIC believes that all Americans should have access to basic health care. While the vast majority of Americans receive health care coverage from one or more of these sources, it is clear that our current health care system falls short of providing coherent, efficient, cost-effective basic health care to all Americans.

The major deficiencies of the U.S. health care system are well known. First, billions of dollars are wasted on inappropriate or poor quality health care each year. Second, government is failing to meet its obligation to provide coverage to the poor and near-poor. Third, and most important, the rapidly escalating cost of health care is forcing both private and public payers to reduce coverage and to attempt to shift costs to other payers. As a result, millions of Americans lack direct access to basic health care or lack the financial resources to obtain such care. Millions more may see their benefits decline and their personal costs increase.

The U.S. health care system, in its present form, lacks the capacity to remedy these shortcomings. For example, expenditures for inappropriate and poor quality care cannot be eliminated from the current health care system because the system as a whole lacks:

- ◆ standards of medical appropriateness, and an effective means to implement those standards, to reduce the high proportion of unnecessary health care expenditures and to eliminate unjustified variations in health care practice patterns;
- ◆ quality measurement systems so that payers are capable of identifying and rewarding high quality health care providers;
- ◆ accountability for the quality and cost of health care delivery; and
- ◆ consistent and effective systems to detect and discipline medical malpractice.

Similarly, the rate of cost increases within the current health care system cannot be controlled because the system as a whole lacks:

- ◆ a coherent marketplace that encourages the efficient operation of economic incentives to contain costs;
- ◆ coordinated health care delivery systems that can provide efficient and cost-effective basic health care;
- ◆ compatible private and public payment systems to prevent cost-shifting among payers;
- ◆ a system to provide payers with adequate price and utilization data;
- ◆ a coherent strategy for allocating capital investment and reducing excess capacity;
- ◆ a centralized system of technology assessment;
- ◆ standardized claims forms and claims procedures to reduce administrative overhead for both payers and providers; and
- ◆ a rational system to compensate medical torts.

Up until now, we have frequently reacted to excess medical inflation in ways that caused the health care system to cannibalize itself. For example, Congress has relied on budget policies that reduce on-budget health care expenditures by shifting billions of dollars in costs off-budget to private-sector payers. Cost-shifting to and among private payers has amplified the effect of system-wide cost increases for many employers, further eroding coverage. The U.S. health care system cannot achieve its objective of basic health care for all Americans, now or in the future, unless we break this cost spiral. Reforms that do not first ensure the creation of an efficient and cost-effective system further delay reaching this goal.

III. FORMING CONSENSUS FOR HEALTH CARE SYSTEM REFORM:

The evidence that our health care system is disorganized and dysfunctional is unambiguous. We must work together to form a consensus for comprehensive health care system reform. ERIC suggests that forming such a consensus entails taking four essential steps:

- ◆ first, we must redefine health care as a product that, by design, eliminates inappropriate care and unjustified variations in practice patterns;
- ◆ second, we must restructure the health care marketplace by replacing current incentives that reward high volume, high cost providers with incentives that reward high quality providers;
- ◆ third, we must reallocate financial responsibility for health care to assure that all payers (including government payers) contribute their fair share to the cost of care; and
- ◆ fourth, we must allocate health care resources to provide consistently high quality basic health care throughout the health care system.

The order in which these steps are implemented is critical. For a comprehensive health care policy to work, it must provide an orderly transition from the current health care system to a restructured system. If we first redefine the health care product, we are in a position to restructure the marketplace to create economic incentives to provide the product we want. If we next redefine the marketplace, we are in a position to reassign responsibilities among individuals, employers and government to assure access to care while equitably distributing costs. If we then redefine who pays for what care, and how they pay for it, we are in a position to reallocate resources more rationally throughout the health care system as a whole.

Taking these successive steps means improving the quality of health care and saving billions of dollars annually, without necessarily having to resort to rate setting in order to contain costs. We need to work together toward a coherent, efficient and cost-effective mixed public and private health care system that is responsive to consumer needs and affordable for everyone who pays for it. If we can slow the growth of system-wide health care cost increases, expanding access to health care coverage will be more feasible, politically and financially. Until the health care product and marketplace are redefined, however, proposals for expanded access will fail to generate broad support, and if enacted, will prove to be an empty promise.

IV. COMPREHENSIVE VERSUS INCREMENTAL APPROACHES TO HEALTH CARE SYSTEM REFORM:

Development of a comprehensive health care policy does not require us to replace the current mixture of public and private sources of coverage with a single national program. It does require the development of a broad-based strategy to restructure the disorganized and dysfunctional health care system to make it coherent, efficient and cost-effective. It also means that incremental approaches to addressing perceived gaps in the health care system -- which in the past resulted in enactment of COBRA continuation coverage, Internal Revenue Code section 89 and Medicare catastrophic benefits, for example -- must be abandoned in favor of policies that simultaneously address quality, cost and access.

Broad federal preemption of state laws relating to private employment-based benefit plans is necessary for comprehensive health care system reform. ERISA, the principal federal law governing employment-based benefit plans, includes a broad provision that preempts most state laws affecting non-insured employee benefit plans. ERIC seeks to preserve and strengthen federal preemption of state laws relating to employee benefits.

Health care products and services are bought, sold, sponsored, merchandized, researched, controlled, cost-shifted, succeeds and fails across state lines. Like many other products and services, health care is clearly encompassed by interstate commerce. Fragmentation of the health care system is not in the interest of employers or employees. ERIC strongly opposes proposals that will permit states to continue to mandate benefits for insured plans, or permit states to tax or otherwise control the health coverage plans of employers that fail to meet specified criteria.

V. PROPOSALS TO REFORM PRIVATE EMPLOYER GROUP HEALTH INSURANCE MARKETS:

In the absence of consensus for the enactment of any of the comprehensive reform proposals currently on the table, some have proposed to address problems in the private group health insurance market without waiting for broad-based health care system reform. Proposals have been put forward by the Health Insurance Association of America, the Blue Cross and Blue Shield Association, and the National Association of Insurance Commissioners, among others. In Congress, several bills have been introduced incorporating similar proposals, including H.R.2121, introduced by Chairman Stark, and H.R.1565, introduced by Representatives Johnson and Chandler.

These proposals address the most glaring gaps in private group health insurance coverage and generally concentrate on the problems of small employers who cannot afford the cost of coverage at today's inflated price. The proposals generally restrict pre-existing condition exclusions, medical underwriting, premium rate increases, and termination of coverage for reasons other than failure to pay premiums. In addition, they require that policies be issued and establish community rating requirements.

While these reforms might bring needed improvements in the group health insurance market for small employers, they are likely to increase the average cost of insurance for many individuals and businesses. Such cost increases will reduce coverage and increase out-of-pocket costs for workers and dependents. Therefore, enactment of such reforms is contrary to the goal of improving access to health care unless group health insurance simultaneously is made more affordable. In an effort to make coverage more affordable, current proposals to reform the group health insurance market generally include one or both of the following approaches:

- ◆ Encouraging or requiring insurers to offer coverage limited to an affordable "basic" benefit package; this is accomplished, in part, by preempting state mandated benefit laws, which expand benefits and increase cost.
- ◆ Subsidizing the cost of coverage from outside the group health insurance market; taxing other employers, including self-insured employers, for contributions to a reinsurance mechanism is one example of direct subsidies that have been proposed.

Preemption of state mandated benefits laws is consistent with ERIC's interest in preserving and enhancing federal preemption under ERISA. Although many major employers self-insure, they are still subject to state mandates when they offer HMO coverage to employees or purchase health insurance policies to cover individual plants or segments of their work force. State mandates artificially increase demand for select health care services. In response, the supply of services increases. In the perverse health care market, increasing supply inflates both price and utilization, and contributes to excess medical inflation for all payers. Frequently, mandating benefits has less to do with real medical needs than with the ability of select providers to fence in their particular interest. Therefore, we strongly support federal preemption of state mandates because it will reduce some health care costs and may increase access to health care coverage to a limited degree.

We also recognize that using federal preemption to create a basic benefit package is an inefficient way to make coverage more affordable. It is a short-term strategy that achieves one-time savings. As costs continue to rise, the basic benefit package must shrink further to remain affordable. Constantly reducing coverage is not an answer to the long-term problem of excess medical inflation.

Requiring self-insured employers to subsidize the cost of coverage in the group insurance market is even less effective. It accentuates inefficiencies in an already perverse marketplace by further shifting costs among payers. The chief result of transferring the risk of catastrophic illnesses from insured plans to self-insured plans is to erode coverage for more workers as self-insured employers respond to inflated costs. It does nothing to reduce unnecessary care or to slow the rate of medical inflation. It is the overall cost trend, not the segmentation of the group health insurance market per se, that is primarily responsible for making health care coverage increasingly unaffordable for companies of all sizes.

Neither "basic" benefit packages nor cross-subsidized reinsurance pools attack the real problem: the escalating cost of our disorganized health care delivery system. Total health care expenditures as a proportion of gross national product have doubled in the span of 25 years. Our goal must be to slow the growth of total expenditures, not merely to "design-down" plan coverage or to shift costs among payers. Focusing federal debate on reform of the group health insurance market diverts attention from the more fundamental need for comprehensive reform of the health care system as a whole.

VI. H.R.2121 AND H.R.1565:

Although there are a number of similarities between H.R.2121, introduced by Chairman Stark, and H.R.1565, introduced by Representatives Johnson and Chandler, the bills differ significantly in their details and methods of implementation.

Since the general issuance and specific contractual requirements of H.R.2121 apply to all insurance policies, not just small group policies, this bill has significant implications for ERIC members who sponsor insured health benefit plans. For example, prohibiting insurers from selling experience-rated policies to large employers will increase such employers' plan costs. Increased costs add another incentive for such employers to self-insure. While the objective of the bill is to reduce segmentation of group health insurance markets, its likely result will be to drive additional employers out of the group health insurance market.

Under H.R.2121, a plan that provides only "core" benefits will not be subject to state mandated benefit laws. "Core" benefits are defined as the same benefits as the benefits provided under Medicare. Certain other preventive benefits and pregnancy-related services are also included. This simply replaces one set of inappropriate mandates with another, imposing on insured plans a legal obligation with uncontrollable costs and open-ended financial liabilities. It will complicate plan administration and require employers to make costly plan amendments. Further, employer plans that exceed the core package for any reason apparently will remain subject to state mandates. Under these conditions, many companies will be unwilling to adopt and maintain an insured employer-sponsored plan.

H.R.2121 also contains a reinsurance pool requirement affecting self-insured employers. It creates a new tax on self-insured employers to fund a federal reinsurance pool. The reinsurance pool in this bill does not appear to raise preemption problems and does allow self-insured employers to participate in the pool. Thus, it may avoid some problems created by other reinsurance proposals. Nevertheless, ERIC opposes a requirement that self-insured employers contribute to reinsurance pools. Employers should have a choice between voluntarily reinsuring their risk by contributing to the pool and internalizing the risk by declining to participate in the pool. Many employers may be able to provide better care, at a lower price, than the pool could offer.

Any reinsurance pool, in isolation, does not address the underlying high cost of health care. It merely redistributes costs. Many of its advantages would be short-lived. It could fuel spiralling health care costs by removing incentives that now exist for employers and insurers to manage high-cost cases efficiently and cost-effectively. A reinsurance pool is a defective tool in the absence of a coherent strategy for cost control.

H.R.1565 contains several provisions that raise concerns among ERIC's members.¹ The bill authorizes states to include "self-insured entities" in the contribution base for reinsurance mechanisms organized by the state. Requiring a self-insured employer to contribute to a pool without receiving the benefit of reinsurance amounts to taxing a benefit the employer is already providing and paying for. This is unfair and will encourage even more employers to reduce their health care coverage or to drop their plans entirely.

H.R.1565 authorizes states to require "each employer health benefit plan (including a self-insured plan) to be registered" with the state's insurance commissioner or superintendent of insurance. Since "self-insured plan" is not a defined term, it is unclear whether the bill is intended to include all employer-sponsored self-insured health plans, only self-insured "multiple employer welfare arrangements" (MEWAs) as defined in ERISA section 3(40)(A), or something else.

In any case, employers are generally required under ERISA to file extensive reports regarding their plans with the Department of Labor. Requiring registration relating to these same employer-sponsored plans with state officials is not only unnecessary, but adds considerably to administrative costs, since each state may impose different reporting requirements. It suggests that state entities have jurisdiction over, and may control the provisions of, those plans. Therefore, the requirement is inconsistent with the principle of broad federal preemption under ERISA. ERIC's concern is further magnified to the extent that the registration requirement applies to self-insured plans.

H.R.1565 requires "each large employer" to offer employees a coverage option that is equivalent to "MedAccess" core benefits. This requirement does not appear to be limited to employers sponsoring insured plans. While the employer need not make any contribution to the cost of coverage, the employer will incur an administrative cost in offering this option to all full-time employees. Few employees are likely to opt for core coverage (with no employer contribution) if they have an opportunity to participate in another plan that includes substantial employer contributions. Full-time employees who are not eligible to participate in the employer's

¹ These concerns are complicated by the use of the term "health benefit plan" in the bill to mean an insurance policy or a health maintenance organization subscriber contract (see H.R.1565 section 121(1)(B)(2)). Under ERISA, an "employee welfare benefit plan" (see ERISA section 3(1)) and an "employee benefit plan" (see ERISA section 3(3)) are defined to include benefit plans established and maintained by employers. They are distinct from insurance policies or subscriber contracts purchased by the plan. This distinction is crucial in the application of ERISA's section 514 preemption provisions. "Health benefit plan," as defined in H.R.1565, is a confusingly similar term with a very different meaning. To avoid confusion with the well-established ERISA terms, ERIC suggests substitution of the term "group health insurance policy or contract" for "health benefit plan" each time it appears in H.R.1565.

plan are unlikely to be offered significantly better coverage than they could already obtain by purchasing an individual policy. Under these circumstances, the administrative burden imposed on employers by the requirement to offer MedAccess-equivalent coverage is unjustified. It will only add to the cost of coverage, further reducing overall coverage.

H.R.1565 also limits the circumstances under which employers can continue to enjoy favorable tax treatment for the cost of providing health benefits to employees and dependents. An employer will be subject to tax unless its plan is:

- ◆ a managed care plan;
- ◆ a plan where employees, on average, assume 30 percent of the cost of benefits under the plan; or
- ◆ a plan where the average monthly employer contribution does not exceed a specified limit.

ERIC finds these requirements troubling. The provision ignores the fact that in many locations throughout the country, effective managed care networks are not readily available. Employers have no control over the availability of managed care products in the marketplace, yet they could be subject to tax if they fail to use one.

If managed care is unavailable, an employer's only alternative is to "design-down" plan coverage where necessary to meet either the cost-share requirement or the limit on employer contributions. Forcing employers to reduce plan coverage is not cost-containment; it is simply shifting costs to employees. True cost-containment requires an attack on the causes of excess medical inflation: escalating physician, hospital and related charges. This provision penalizes employers and employees for increases in health care costs that are beyond their direct control. As such, it is punitive and inappropriate.

Both H.R.2121 and H.R.1565 fail to address the needs of the health care system on a comprehensive basis. While each bill is an important step toward developing consensus, neither bill addresses the fundamental problems we face. For the reasons articulated above, ERIC opposes both bills.

VII. CONCLUDING REMARKS:

ERIC believes that before Americans who currently do not receive health care coverage (either from an employer or another source) can be provided access to affordable health care, the current health care system must be made more coherent, efficient and cost-effective. ERIC believes any legislative proposal should, at a minimum, incorporate the following four elements:

- ◆ A comprehensive framework for simultaneously addressing quality, cost and access in the health care system.
- ◆ A coherent strategy for eliminating unnecessary care and containing medical cost inflation for the health care system as a whole.
- ◆ A coherent strategy for distributing health care costs among individuals, employers and government on an equitable basis, including the elimination of cost-shifting among payers.
- ◆ An opportunity for major employers to continue to be the primary source of health care for employees and their dependents.

Thank you for the opportunity to appear before you today. I will be pleased to answer any questions.

Chairman STARK. Let me ask a couple of questions, Mr. Heslin. Aren't you basically recommending an all-payer system? I mean, don't you have to have that to get what you just said, where there can be no cost shifting, all payers will pay an equitable share—you just said that, and really you are—

Mr. HESLIN. That could be the result, but no, we are not saying to go at it—

Chairman STARK. But we have to have it, don't we? How are we going to stop cost shifting? If you let one guy be out in the market, then everybody else pays more. Let us just say that one guy is a huge gorilla and can affect costs.

I mean, just technically, I don't care whether it is all-payer or single-payer, but if you are really going to keep costs from getting shifted at all and everybody pays their fair share, you have to get to a point where you have all the—

Mr. HESLIN. Mr. Chairman, you have to start with the cost itself. You have to start working that cost down.

Chairman STARK. But is there any other way to do it? I honestly don't think there is. If you want to stick to your parameters, which is don't let anybody out of the box, and everybody pays—let us say that a hospital room fair price is \$1,000. Don't we just have to, government and ERISA and private insurers and Blue Cross, all have to say, we are going to pay \$1,000, and then that is the fair amount, and the hospitals will have to figure out how to operate efficiently.

They are a utility, let us say. I mean, that is what we have to say. I don't see another way really. Somebody accused me of that. This guy Stark wants to make hospitals a utility. It is not so bad in the communications business, is it? [Laughter.]

Mr. PERES. I am not going to handle that one.

Chairman STARK. It doesn't work bad if you are selling electricity.

Mr. PERES. I think one of the problems in only looking at the hospital's cost or price is it leaves out other parts of the equation. We can go to the hospital or to a physician and say, in return for some contracted performance standards, some willingness to open yourself up to third party examination from the outside for quality, we will direct people to you. But also in return, we are looking for something else, and—

Chairman STARK. But you have to protect the guys who don't have your buying power, that is the point.

Mr. PERES. Well, I will say that we can do that.

Chairman STARK. OK.

Mr. PERES. I can give you two specific examples.

Chairman STARK. I could do it easier. I don't have to negotiate with the Communication Workers. They don't support me to begin with. I could just go in and we could just do it. That wouldn't be bad, would it?

If you could get every one of your workers into a hospital at what I pay at Medicare rates, you would probably save some money. And you know something? The hospitals wouldn't go broke, because if they got that Medicare—not Medicaid, but Medicare—rate for everybody who came through the door, no charity, no bad

debt, no uncompensated care, they would survive. Then we could go on and do other things.

I don't expect you guys to sign up for it today, but you are talking about it, and you go around the edges. Yet when we come back, Mr. Heslin almost said we ought to have an all-payer system.

Mr. HESLIN. No. I don't think you heard that.

Chairman STARK. Yes. I sure did. No, it is in your testimony.

Mr. HESLIN. Our position is that before you can get to answer that question, you have to deal with the system that you have now, which is too expensive—

Chairman STARK. Yes.

Mr. HESLIN [continuing]. And we are all shifting. I am shifting to him, he is shifting to me—

Chairman STARK. I am shifting to you.

Mr. HESLIN [continuing]. You are shifting to me, that is right.

Chairman STARK. Why don't we cut that out?

Let me ask you another question. Why is it fair, and I am going to assume that Rockwell has a generous plan and Ameritech has a more generous plan than Nynex did. You guys didn't have a strike, right?

Mr. PERES. We didn't have a strike over those issues.

Chairman STARK. I have been informed that Chrysler pays \$3 or \$30 million a year for benefits that they pay to the dependents or spouses of Chrysler employees who have health insurance available through their employees. It is costing Chrysler \$30 million a year.

In other words, because Ameritech or Rockwell may have a generous plan, but your employee's spouse may work for someone who has not quite as generous a plan, therefore, you guys are getting hooked for the kids. Is that fair? Is that fair to Ameritech? Is that fair to Rockwell?

Mr. HESLIN. We have what we call a non-duplication clause, and that is—

Chairman STARK. You do?

Mr. HESLIN [continuing]. If you are covered there, then they pay first, and we don't pay—

Chairman STARK. No, but what if it is available to you but you choose not to pay for it? In other words, I am working for you and my wife works someplace where the benefits are not quite as good as yours, so she doesn't sign up, and I cover it by buying the family rate—

Mr. HESLIN. Dependents are covered under the birthday rule, and that is whichever spouse is first born in the year, the month and date of birth, that is whose employer has to pick up the costs for that. That is called the birthday rule.

Chairman STARK. Is that fair?

Mr. HESLIN. It must be, it was legislated. [Laughter.]

Chairman STARK. Well, you have me there. [Laughter.]

I guess what I am trying to get at is this. What is wrong with the idea that we get away from the employer-based provision. I am not suggesting that we are going to let you guys off the hook for paying for it, but what is so magic about it being tied to employment? Neither of you are old enough to remember the 30s, but you didn't provide health insurance in the 30s. You may have at Wisconsin Bell, but mostly there wasn't any available. And the only reason you did

it is because Roosevelt came along and said you couldn't have any wage increase, so—

Mr. HESLIN. It was excess profits tax, yes.

Chairman STARK. Yes. Is there anything magic about saying—you don't like mandates, but let us say that we had a rule where everybody has to have insurance, and they have to go buy it from a company or it has to be available from a multitude of private insurers.

You may have to contribute through bargaining, but you only are responsible for your employee, and then somehow we have to figure out who—the taxpayer, if that is your employee, is responsible for his or her own spouse and kids. Now, if you want to bargain for that, then they pay less.

We are always going to have 20 to 30 million uninsured people. I think there are about 60 million people not insured if you take a moving target, say at any point in about 13 months, which is about as bad as not having insurance. There are that many who are not in the system at some point during a year. On any day, it is maybe 30 to 40 million.

We are always going to leave 20 million of them off the table, and they are going to increase your costs, because they are the ones who go to the emergency room, and so the hospital has to jack up their rates to pay for you.

Do we have to have that employment-based system? Would it trouble you if we thought about other ways to do it? As long as your costs didn't go up and you had the option of trying to get a better price?

Mr. PERES. From the perspective of APPWP and I from my own company's perspective, the preference is to do it through the employment-based system. It means having to find ways to cover those people who are in transition or who are not working, but the reason that we—

Chairman STARK. Do you think you would be the same if we took away your tax deduction for it?

Mr. PERES. We, at least within Ameritech, have not discussed it in the context of tax deduction. We have discussed it in a context of who do we think can do the best job of looking out for our employees. And we believe that—

Chairman STARK. A professional can do a better job, there is absolutely no question—

Mr. PERES [continuing]. That we can do that, and we do have 75,000 active employees and 45,000 retirees, some of whom are covered under Medicare, but we do cover them on a secondary basis. We feel that we can look after them much better than putting them all into a single national, or even State-level, pool.

Chairman STARK. If the social responsibility genes hadn't been fully depleted when the Bells were broken up and had your disease spread to Nordstrom and McDonald's and other farsighted employers, I would be with you. We do have those in their community who are not picking up their fair share with the same attitude that you are.

Mr. PERES. I can't speak for any other employer. All I can do is say that when we do what we do, we try to do it with community responsibility in mind.

As we had started to talk earlier about the small groups and individuals, Wisconsin Bell, which is one of our companies, participates in an employer-based PPO, and was one of its founders. One of the requirements of that group is that they make it available to small groups, to small employers, and they have done that through some local insurers.

Chairman STARK. But you have to remember Milwaukee had socialist mayors for years, too. It is probably the chlorine in the water, but——

Mr. PERES. Well, I can move down south of the border into Illinois, and——

Mr. HESLIN. We are in Milwaukee too, so——

Mr. PERES [continuing]. With our dealing with Blue Cross of Illinois, where we have pushed them in the area of managed care. Within 18 months or 24 months or our having done so, all of their individual and small group policies required either PPO's, utilization review, programs of that sort.

We are now implementing a point-of-service network, and I am sure that within a very short period of time, that is also going to be part of the small and individual group market.

So I think that in many respects, we can get the insurers, get the HMO's to do things they might not otherwise do, and that does benefit everybody that is utilizing those services.

Chairman STARK. I am reminded by my staff that I am old enough to recall that the Federal Government was really the innovative force behind HMO's. You suggested that business does all the innovating. Some of us even remember that we had to lead businesses with a very tough nose bit to the trough of managed care and HMO's as they came screaming socialism.

I don't know why they always call it socialism. When I dream it up, they call it socialism, and when Califano and Iacocca dream it up, it is free enterprise.

But somewhere in between, I hope that we can work together on this because it is a problem that large businesses have a much closer alliance with us. You guys are basically doing what is right, and you are paying more than your share of costs for the most part.

So I have a hunch that you will be our first ally in some kind of a universal plan, because it will save you money—a lot of money. If Chrysler can come to the table with us and say the cost of insurance goes from \$700 a car to \$300 a car, and it is a reasonable plan—I am not sure of that. I think that is a little more than we could take.

But particularly if I take you off the hook, which I think we are going to have to do for your unfunded liability on retirees' costs—you may be funded, but I doubt it—we are told that that may be \$200, \$300, even \$400 hundred billion, and I can't believe that we are not going to be asked as the Government to bail out industry in general from that rather catastrophic cost that nobody really quite anticipated. I think we would be willing to do it, but then the price is to shift the costs around.

One final question. You mentioned—one of you mentioned, and I think it was Mr. Heslin—a fair way to spread this cost. Is that what you alluded to? Is that fair way, progressive as a tax system

that is supposed to be, that high income pay more, poor people pay nothing?

Mr. HESLIN. Well, that wasn't it. Our point was that we will pay our share of it. We don't want to pay for somebody else shifting the cost over to us.

Chairman STARK. OK, but what among all people who have to pay, say, for the costs of the uninsured, for the poor. Shouldn't we all have to pay for that according to our income level?

Mr. HESLIN. We pay for that now.

Mr. PERES. When we talk about spreading the costs, at one end a broadly based tax, whether that is progressive, or not, and at the other being similar to what they did in States like New Jersey where you have, in effect, a tax on hospitals.

The letter puts the burden on the people that can least afford to take care of that burden, and that is what I think most people are against—

Chairman STARK. I don't like that. I mean, it puts a tax on the guy who is already sick. That is like kicking him when he is down. And I don't like consumption taxes just philosophically.

But if that was all that was standing between me and the administration for a universal health program, don't put your hand between my pen and the paper while I sign up for a national sales tax to fund a national health system. I could see that happening. I don't think that is very likely.

As I say, you both represent people who have been in this business longer than the Federal Government has been in the Medicare business. We are going to have to solve it together, and I think that any solution can only save you guys money.

I mean, I don't really see that anything we do can drive your costs higher as we include other people in the system as long as there is a fair way to pay for it.

Mr. HESLIN. If you don't reform the medical delivery system—you see, you are talking about the insurance approach—

Chairman STARK. Let me tell you something though. As a politician, I like to get stuff done. As a manufacturer, you like to make things and sell them. My mother is my test. We have Kaiser, and half of the people in the county that I represent belong to Kaiser—a half a million people in one program. Kaiser has been around 40, 50 years. It is unique, but it is good.

And I say, Mom, you ought to join Kaiser. No way. I mean, mom grew up in Milwaukee, and she had a doctor, and she is still going to have a doctor. She will go out and humiliate me. She will sleep on a grate before she will let me make her join Kaiser. Now, some of our children are in Kaiser and you couldn't get them to do anything else.

We are not going to be able to change legislatively the delivery system. We can probably bargain with the delivery system for what we pay. Medicare has done a good job on bargaining with problems. Sure there has been some shifting, but maybe that is because the hospitals haven't saved any money either. They have been brought up on a full-cost reimbursement, and even I couldn't make money for Rockwell if I got every penny of cost back that I spent. So, we are not doing bad.

If the doctors cooperate with us, we might work on this payment system. Now, I think the only thing we can really begin to revise is the reimbursement system in this country. I mean, politically speaking, I don't think we are going to change the way they practice. Maybe over a longer period of time, as we get outcomes research and that sort of thing.

And I don't think you want us, as legislators, putzing around with how the doctors practice. We can facilitate it by providing an information base, and we can bargain. But we don't have any easier a time bargaining than you guys do when you are bargaining with the CWA.

Mr. HESLIN. But what you do is critical. You see, if you do the reform on the small business market like you are talking, that just increases our costs. You are just giving access, and if that is the goal, that is all that you have accomplished.

Chairman STARK. Well, I am not sure we do. In other words, I guess it depends on where you are and what State you are in, but if I take the uncompensated costs off the books, the charity costs, then the hospitals you are bargaining with don't have that cost any more, and so they don't have to charge you, a good-paying customer, enough to make up for the emergency room traffic that doesn't pay them anything that our laws make them take.

I mean, if they are obeying the antidumping laws, they are providing care to everyone. These people get care. The trouble is, they get it at such a high cost to the system that we are all paying more.

Now I can't convince you, I don't suppose, because I don't know that Rockwell will save as much as it might cost them for universal coverage. And I don't know why your costs would go any higher if we insisted on no medical underwriting, open enrollment, and community rating, because I doubt if either of your companies are dumping your high-cost cases onto the private sector, but there are some who do.

I mean, if you have a good guy like the New York Blues who take all risks, open enrollment, you would have to be a pretty dumb employer to say I have this small group of very elderly, very sick people. We will shove them into that program, and then we will continue to self-insure for the balance.

All I would say in my bill to you is that you have to continue to have your affinity group. I don't know as there would be any change. What you would hope to do is to get every other health insurer to do what the Blues do and that is to have open enrollment. To some extent, we would have to subsidize for a while—I think—the high-risk stuff. But my feeling is we do it for you as well.

In other words, let us say that it will cost \$50 a year for every worker, and the government will pick up all the costs of that case in a year of over \$30,000. We take the high-end stuff, and then every employee is assessed a fee.

I don't know if those are the numbers, but I am just saying, you would save the risk that you get by getting caught with, say, an AIDS case, and you pay so much, as would everybody else. I would think that you would get as much benefit as you give there. And if everybody was in the pool, you would have to save money. That just limits your liability.

I don't think I could sell it, and it certainly isn't our intention to make you and the United Auto Workers and others pay for this. I don't think we have the foggiest idea that that would work. The idea is that spreading the risk seems to save money, and if we can get everybody in the box—the high costs of the system came from those uninsured people who come in too late, usually through the emergency room rather than from a primary care physician early on.

Mr. HESLIN. That is not the only reasons for the high cost, though, because you have that medical technology problem.

Chairman STARK. No question.

Mr. HESLIN. There is more MRI equipment in the Twin Cities than there are—

Chairman STARK. You guys sign up on my ownership referral bill, and we will save a few bucks there, believe it. No, you don't make them, but—

Mr. HESLIN. No, G.E. does.

Chairman STARK. G.E. does, I know. But they might endorse it. They are going to sell them anyway, so they are doing fine.

Thank you. I just hope that we can continue to keep this dialogue going. There is a lot of pressure out there. There is no leadership in Washington to get anything done.

But let me ask you that. How would you guys like to sell Dr. Sullivan's program to the Communication Workers—celibacy, abstinence, and exercise? [Laughter]

Would you like to sell that one across the bargaining table?

Mr. PERES. No.

Chairman STARK. All right. Thank you very much for your participation.

[Whereupon, at 2 p.m., the hearings were adjourned.]

[Submissions for the record follow:]

STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION
to the
Subcommittee on Health
Committee on Ways and Means
UNITED STATES HOUSE OF REPRESENTATIVES
RE: Small Market Health Insurance Reform

May 23, 1991

Reforming the small group health insurance market is an essential first step in reforming the U.S. health care system. Employers, especially small employers, cannot be expected to provide health coverage to their employees until health insurance is made a more accessible and affordable product. The American Medical Association (AMA) commends this Subcommittee and its Chairman for your leadership in seeking small market insurance reform, and hopes to work with this Subcommittee and others to achieve this needed reform in the 102nd Congress.

During a series of recent hearings, the full Ways and Means Committee explored in detail the genesis, development and possible outcomes of this country's "access crisis." The hearings bore out an important message: although there are divergent approaches to long-term health system reform, there is a consensus building on four incremental reforms that are obtainable in the short-term. These reforms -- small market insurance reform, preemption of state benefit mandates, medical liability reform and requiring the self-insured to participate in state risk pools -- offer a measure of significant and immediate relief from the problems of increasing costs and uneven access. These reforms are integral elements of Health Access America, the AMA's proposal for health system reform, and we support their expedient implementation.

HEALTH ACCESS AMERICA

Health Access America is premised upon the fundamental principle that our current health system has many strengths. Our system serves the vast majority of America; approximately 213 million or 87% of all Americans enjoy access to health services through existing public or private insurance. In addition, our system offers the most sophisticated health care in the world. A key element of the success of the U.S. health care system is its reliance on the private sector and freedom of choice, which promote innovation and diversity.

We believe that the existing public/private partnership in health care must be maintained to ensure that the "best" of our system survives and prospers. Other countries' experiences have shown that the fundamental strengths of our system -- technological superiority, quality, competition and freedom of choice -- would not survive in a monolithic, centralized system. Accordingly, the AMA advocates strengthening, not abandoning, our current health care system. This approach will allow us to improve access and eliminate unnecessary costs without jeopardizing the access currently available to 87% of all Americans.

Employment-based Coverage

The cornerstone of Health Access America is expanding access to the over 20 million employed but uninsured by requiring employment-based health insurance.* The proposal calls for a phased-in requirement that employers provide coverage to all full-time employees and their dependents. Initially, only very large employers would be subject to this requirement; over time, the requirement would apply to all employers, including smaller and new businesses.

The AMA realizes that this is a tall order for some employers, especially those with small and new businesses. Given the fact that many of our members' practices are small businesses, we are acutely attuned to the interests and needs of small companies. We propose to meet these needs and interests by providing a series of significant insurance market reforms and financial incentives.

Insurance Market Reform and Other Incentives for Small Business

Before small employers can be expected to provide health coverage, small group insurance must be made affordable and accessible. The following reforms are essential:

- community rating across all small groups;
- no pre-existing condition limitations;
- guaranteed acceptance of all employees, possibly through an assigned-risk approach, with an initial minimum coverage period of two years;
- guaranteed renewability with limits on premium increases; and
- the required offering by carriers of an essential benefits health policy. (A copy of the AMA's essential benefits package is attached.)

These market reforms are necessary to eliminate the risk avoidance tactics practiced by some insurance companies -- such as denying or limiting coverage, and employing "low-ball/high-ball" premium and sales techniques -- that inevitably cause employers to forfeit coverage. We see small market reform as an essential first step in obtaining system-wide reform, and we commend Chairman Stark and Representatives Johnson and Chandler for their legislative initiatives in this area.

Additional reforms and incentives that must accompany employer-provided insurance include amending federal law to provide for the participation of self-insured entities in risk pools, making permanent and increasing to 100% the deduction allowed the self-employed for their health insurance premiums and providing tax incentives to new and small businesses. Finally, the approximate 800 state benefit mandates should be preempted, and employers should be given the option of providing a more affordable essential benefits package such as the Health Access America package.

* In combination with employer-provided health insurance, the AMA strongly supports Medicaid reform to ensure that everyone below the federal poverty level (state-adjusted) would receive a uniform basic benefits package. We would address the increasing costs of our system through several measures, such as: technology assessment and outcomes research; the development of practice parameters; implementation of physician payment reform; appropriate cost-sharing and tax treatment of health coverage; replacement of state benefit mandates with an essential benefits package; reform of the medical liability system; health promotion; amendment of the federal antitrust laws to allow local fee review; and continued societal examination of the priorities for health spending.

- 3 -

CONCLUSION

The time for health system reform is now. The long-term reform proposals being debated are as diverse and complex as the health problems this country faces. Yet, a consensus is emerging on incremental reform measures that are achievable in the short-term, and that will go far to address the primary problems of cost and access. Small market insurance reform is one such measure. The American Medical Association views small market insurance reform as an essential first step in obtaining system-wide reform, and we offer our efforts to this Subcommittee to help achieve such reform in the 102nd Congress.



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WM P. WEBB II, B.S. D.C., Director

April 25, 1991

The Honorable Pete Stark, Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
1114 Longworth House Office Bldg.
Washington, D.C. 20515

Dear Mr. Chairman:

The purpose of this letter is to address the Committee on Ways and Means to the hearing on Health Insurance Options; Reform of Private Health Insurance. The background quoted from the press release #7 by the subcommittee dated on Friday, April 19, 1991, states "various practices of the insurance industry appear to increase the problems faced by employers in purchasing health insurance." I'd like to throw a few statistics out for consideration that dramatically increased the coverage of insurance, but not necessarily related to the insurance company itself. Two studies of late concerning "Iatrogenic Reactions of Medications and the Side Effects" was performed by Yale New-Haven Hospital showing that 100,000 people die and 1,500,000 others are hospitalized from iatrogenic reactions every year in this country. That means that each WEEK, 3000 people die and 30,000 are hospitalized from the medications they take for the illnesses, not from the illnesses themselves!

An additional 48,000 people die each year in the United States from unnecessary surgery, according to the John Hopkins Study. That's nearly 1000 deaths a week from surgery that would not have been performed.

Further--in a clinical study of a hundred patients conducted by AV-MED, the largest HMO in the southeastern U.S., 17 patients were diagnosed as having "slipped discs". Twelve of the seventeen were told they needed surgery. All twelve disc cases were corrected through chiropractic adjustments--without surgery. AV-MED saved an estimated \$250,000.

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In this study by AV-MED, called the Silverman Report, 80% of the patients were medical failures, who had been seeing an average of 1.6 MD's without results. Within three weeks, 86% of this group had their problems corrected through chiropractic.

In 1986, a thirteen year study by the U.S. Office of Public Health, found that 2/3 of all of the over-the-counter drugs do not do what the promoters promise. This government study makes it clear that drug advertising is not a trustworthy source for health care and information.

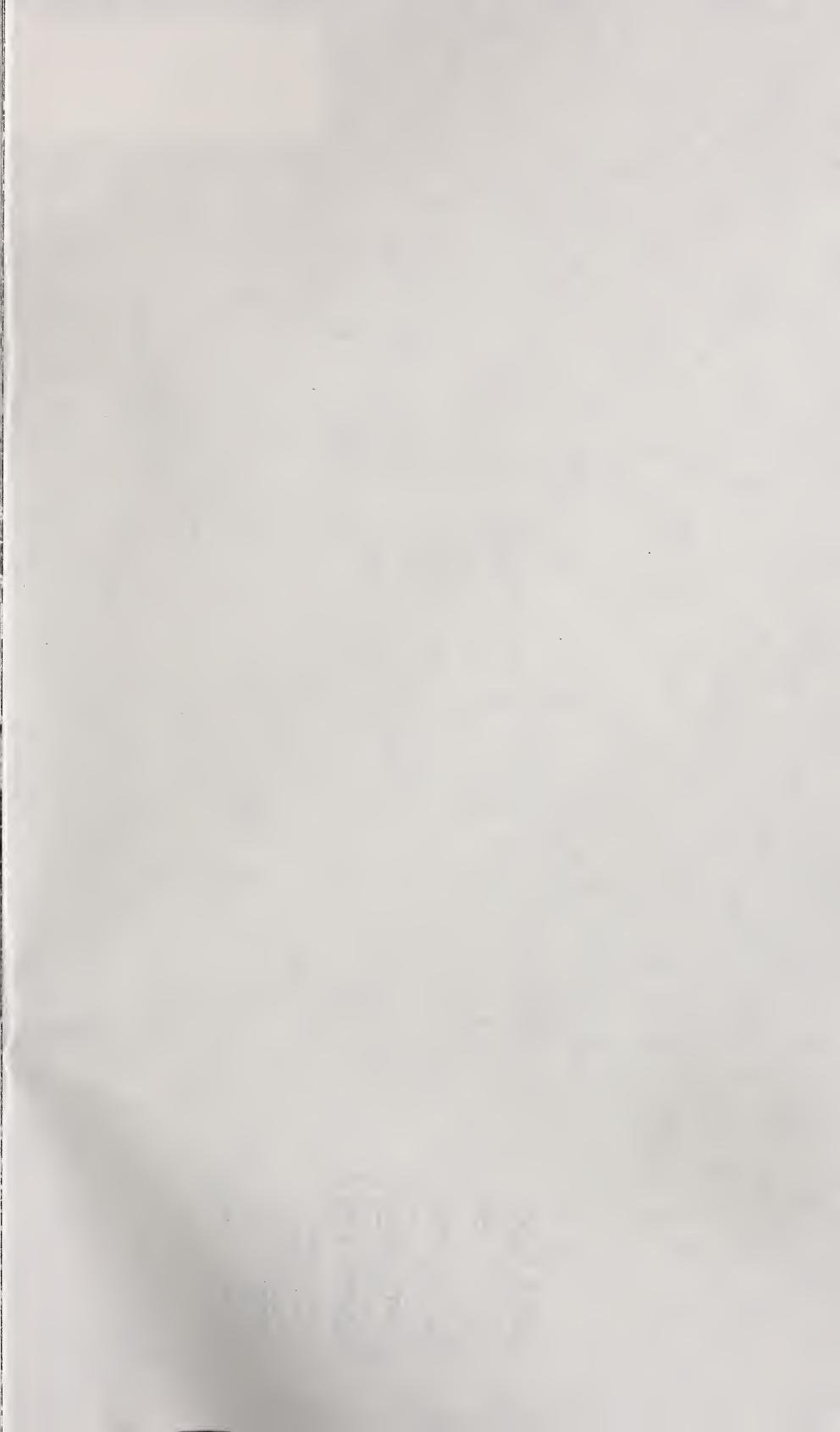
The above statistics are very apparent that in the setting of rates by the insurance industry is not necessarily set by experience rating as opposed to community rating in the increases of prices of insurance to the small businesses. The statistics above are accurate, and I believe they are because they were performed by reputable institutions of like kind on other practitioners of like kind, I feel there is a drastic need for the insurance industry and other related health organizations to formulate some ways and means of disciplining and/or educating we the consumer from the disasters that lay ahead of us by unnecessary surgery, improperly diagnosed conditions, and health potions that do not work. The insurance companies, by far, are having to foot the bill for all these misnomers, and as a result of same, our premiums have escalated. I realize that this is not all the fault of the health industry and part of it is the fault, in my opinion, of the insurance industry, but I suggest Representative Stark set up hearings to discover why these statistics, listed above, are so out of order, and in doing so, possibly lower insurance risk and our rates.

Respectfully,



Wm. P. Webb, II, B.S.D.C.





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